# MILITARY CONSTRUCTION AND VETERANS AFFAIRS, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2012

**THURSDAY, MARCH 31, 2011**

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
*Washington, DC.*

The subcommittee met at 10:05 a.m. in room SD–124, Dirksen Senate Office Building, Hon. Tim Johnson (chairman) presiding.

Present: Senators Johnson, Inouye, Reed, Nelson, Tester, Kirk, Murkowski, Blunt, and Hoeven.

## DEPARTMENT OF VETERANS AFFAIRS

**STATEMENT OF HON. ERIC K. SHINSEKI, SECRETARY**

**ACCOMPANIED BY:**

**HON. ROBERT PETZEL, M.D., UNDER SECRETARY FOR HEALTH**

**MICHAEL WALCOFF, ACTING UNDER SECRETARY FOR BENEFITS**

**STEVE MURO, ACTING UNDER SECRETARY FOR MEMORIAL AFFAIRS**

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### OPENING STATEMENT OF SENATOR TIM JOHNSON

Senator JOHNSON. Good morning. The hearing will come to order.

We meet today to review the President's fiscal year 2012 budget request and fiscal year 2013 advanced appropriation request for the Department of Veterans Affairs (VA).

Secretary Shinseki, I welcome you and your colleagues, and I thank you for appearing before our subcommittee.

I also welcome Senator Kirk as the new ranking member, and I look forward to working with him and with all the new and returning members of the subcommittee as we move the fiscal year 2012 budget process forward.

Before getting started with my opening statement, I want to recognize the chairman of the full Committee and the most senior member of the subcommittee, Senator Inouye, for any opening remarks he may have.

### STATEMENT OF SENATOR DANIEL K. INOUYE

Senator INOUYE. All right. Thank you very much, Mr. Chairman.

I am here to acknowledge and commend the work of the Secretary of VA because while bringing about a new culture of efficiency, he has been able to set up a system wherein hospitals are now working with universities and major hospitals. Men and women who we consider to be hopeless cases are now hopefully getting up—comatose patients. I have seen those men and women who are now benefiting from the work of this Department in new prosthetic appliances, and that is a new specialty on my part.

What you have achieved here is almost miraculous, and I want to commend you.

I am also here for a personal reason. I have the pride of having nominated General Eric Shinseki when I was in the House of Representatives. That is a long time ago. That makes me ancient. And here he is now the head of VA and former Chief of the Staff of the Army.

I wish I could stay here, General Shinseki, but as you know, we are trying to resolve the budget, if it goes well, we will do it. So if you will excuse me, sir, and Mr. Chairman, you will excuse me. Thank you very much.

Senator JOHNSON. Thank you, Mr. Chairman.

In order to reserve the majority of the time for questions, our procedure will be to have opening statements by the chairman and ranking member, followed by an opening statement from the Secretary. We will limit the first round of questions to 6 minutes per member, but we can have additional rounds should we need them.

The overall fiscal year 2012 budget—discretionary budget request for the VA totals $58.8 billion, $1.8 billion more than last year's request. Additionally, the submission also includes a fiscal year 2013 medical care request of $52.5 billion.

Mr. Secretary, I would note that outside of the increase for medical care in the fiscal year 2012 budget submission, that the Department's request for all other functions is down, a combined $859 million from last year's request.

I understand and appreciate that as budgets get tighter, Departments are being asked to do more with less. But I want to make sure that these cuts will not erode services or diminish the quality of care that veterans receive.

In particular, I am concerned about the 25-percent reduction in the request for the construction and facilities accounts, and the impact this may have on the adequacy of VA medical facilities and healthcare deliveries in future years.

VA has a $9 billion backlog in repairs and improvements to existing buildings, and I am concerned that this budget does not adequately address that requirement.

Before I turn to my ranking member, I want to point out that the VA is estimating that the average wait time for disability claims will reach 230 days in fiscal year 2012. This is totally unacceptable. This subcommittee has provided the VA with significant resources over the past several years, including an additional $460 million in the current continuing resolution for fiscal year 2011, which the Department said was needed to reduce the wait time and backlog. Yet the problem is getting worse, not better.

I understand that the decision on Agent Orange claims and the complexity of new claims have added to the problem, but the VA

needs to come up with a comprehensive plan to solve this problem sooner rather than later.

I will have specific questions on these and other topics after your testimony. So I will end my opening statement here.

Senator Kirk, welcome, and do you have an opening statement that you would like to make?

STATEMENT OF SENATOR MARK KIRK

Senator KIRK. Thank you, Mr. Chairman, and thank you for having me to be a new member of this subcommittee. And, Senator Reed, it's an honor to be serving with you, especially after your nasty habit of jumping out of perfectly good airplanes on behalf of the——

Senator REED. I was just trying to emulate the Secretary.

Senator KIRK. That's right.

Mr. Chairman, I really look forward to working with you, Tina, Chairman Culberson, and Tim, and especially Dennis Balkam, Ben Hammond, Patrick Magnusson, and you, Mr. Secretary.

After Operation Iraqi Freedom, you have been very much a personal hero of mine, and I particularly have been proud of your work on the Stryker, and in a reserve capacity, I was a customer of that vehicle. And I want to touch on Stryker later during this hearing because I think its philosophy has bearing on the Department.

Now, I have served in the Navy Reserve for 23 years, and on top of that, 10 years in the Congress. My major work with the VA was regarding the North Chicago Veterans Medical Care Center, which was the first ever to truly combine with a military hospital, Great Lakes. And that combination has led to a number of groundbreaking precedents, to be topped off by it being named after the Commander of Apollo 13, Captain James A. Lovell.

We have about 780,000 veterans in Illinois, 5 Senators, 26 clinics, 12 veteran Senators. And I am looking at your budget now, and it is a hefty sum, needed for our veterans, $181 billion. We are aware that 40 cents of every Federal $1 is borrowed. Now, that would mean $72 billion of this money is borrowed, one-half of it from abroad. And so, the increased scrutiny that that has given us a chance to look at your budget. I know that you are at about $5.7 billion more than last year.

Key issues for me are medical records, and the Stryker model is the model that I hope we follow here on this subcommittee and in the Department—no new invention; commercial-off-the-shelf only, with a complete inability for beltway bandits and propeller heads to get into your decisionmaking cycle and procurement and try to invent something new that in the end will be too ambitious, too expensive, and will fail during your operational time with us. The Stryker model was to bring in a project and complete it within your secretary-ship, and my hope is that we are able to do that with medical records of inventing as little as possible.

On the care provided to veterans, I first was concerned about incidents in my own State of Marion, Illinois. We also understand that we have had 2,500 veterans exposed to HIV in Miami. In Philadelphia, the cancer unit at the VA botched 92 of 116 radioactive treatments over 6 years and then tried to cover it up. The

VA suspended similar programs in Cincinnati, Ohio, and Jackson, Mississippi. And in St. Louis, very much a part of our State's veteran's picture as well, we had to improperly sterilize tools, exposing 1,800 veterans to HIV.

I think that much of this has come to light because of you and your added scrutiny and focus on medical standards. And I hope that we will hear about how we are upgrading that, especially at those facilities.

I share the chairman's concern about claims. Justice delayed is justice denied. My understanding is this subcommittee has provided $277 million extra since 2007 for additional claims processing, but as the chairman highlighted, adjudication times have climbed from 165 days to 230 days just in the last 2 years.

I am particularly concerned about the idea of a contingency fund. I talked about this with Chairman Culberson. I do not have a big problem with your top line, and so I think we should just roll it into your regular budget. Estimate what you need, then the subcommittee should provide it. But I think the House of Representatives is not going to be approving any contingency funds. I just talked to the full Committee chairman; he understood that, and I think he is amenable to going in the same direction, at least as of this morning. And so, my hope is that we do not set the precedent here. I think it would be a very failed precedent in the House anyway. My hope is just to team up on a good top line which reflects your actual needs.

With that, Mr. Chairman, let me just say my only hope for you, General Shinseki, was that you had gone Navy instead of Army, but it has been a very impressive career.

And Mr. Chairman, I yield back.

Senator JOHNSON. Thank you, Senator Kirk.

Mr. Secretary, again, I welcome you to the subcommittee. I understand that yours will be the only opening statement. Your full statement will be included in the record, so please feel free to summarize your remarks.

Mr. Secretary.

SUMMARY STATEMENT OF HON. ERIC K. SHINSEKI

Secretary SHINSEKI. Thank you, Mr. Chairman.

Chairman Johnson, Ranking Member Kirk, distinguished members of the subcommittee, thank you for this opportunity to present the President's fiscal year 2012 budget and fiscal year 2013 advanced appropriations request as two documents for this Department.

I thank the members of the subcommittee for the generosity of time and meeting with me prior to this hearing.

Let me also acknowledge the presence of some of our veteran service organizations. Their insights are helpful as we structure our programs to best meet the needs of veterans. And so, their insights are useful.

Mr. Chairman, thank you for allowing the introduction of my written statement.

Let me just very quickly say that the President's fiscal year 2012 budget request would provide $132.2 billion to VA to meet its responsibilities; $61.9 billion of that is in discretionary funding,

which is our primary discussion today, and the remainder of that, $70.3 billion, in the mandatory account.

Our discretionary budget request represents an increase of $5.9 billion or a 10.6-percent increase over the last enacted budget, which was fiscal year 2010.

The budget request for fiscal year 2012 and advanced appropriations request for fiscal year 2013 continue the strategic cultural change that has been underway in VA now for at least 2 years. They also enable our pursuit of three urgent priorities that have also guided our efforts for the past 2 years, namely expanding access to VA benefits and services to the topic that both the chairman and ranking member addressed, reducing and ultimately eliminating the claims backlog, and then third, ending veterans homelessness by 2015.

I would like to touch on each of those very quickly.

ACCESS

In 2008, 7.8 million veterans were enrolled in VA for healthcare. Today, that number is 8.4 million, and it is estimated to go to 8.6 million veterans in 2012, the year of the budget we are looking at is an increase of 800,000 enrollments in 4 years.

Veterans continue to be among the oldest and sickest patients in any medical system, and the youngest of them are challenged by increasingly complex injuries and the insidious wounds that we all know about from these current conflicts. Most of them are challenged economically, and so this budget request allows VA to address this surge in demand at this time given the circumstances facing our veterans.

THE BACKLOG

VA's highest priority is to eliminate the disability claims backlog in 2015, ensuring all veterans receive a quality decision with an accuracy of 98 percent in no more than 125 days. We have a ways to go to meet that goal.

Major information technology (IT) investments have been made to supplant the Veterans Benefits Administration's (VBA's) paper-bound processes with Veterans Benefits Management System (VBMS), being piloted today in Providence, Rhode Island, something that has been underway since November of last year, and Veterans Relationship Management (VRM), another initiative in the process of being fielded. We anticipate significant progress in 2012.

The fiscal year 2011 and fiscal year 2012 budget requests are intended to posture us to begin reducing that backlog in disability claims.

HOMELESSNESS

Two years ago, there were approximately 131,000 homeless veterans on any given night. Today, that estimate is down to 76,000 veterans. We intend that number to be less than 60,000 by June 2012. We have made progress, and this budget request allows us to put in place the detailed plans to both rescue and prevent homelessness amongst veterans. Healthcare for homeless veterans costs

three-and-one-half times more than what it costs to care for veterans who are not homeless. There is a cost factor associated here. This budget request enables pursuit of our goal to eliminate veterans' homelessness by 2015.

For more than 2 years now, we have established and reinforced the importance of the right behaviors, disciplines, processes, and the leadership it takes to become more effective, accountable, and efficient as a Department. Our budget is large and complex with the country's largest integrated healthcare system, the largest national cemetery system in the country, repeatedly recognized as the country's top performer in customer satisfaction over the past 10 years, the country's second-largest educational assistant program, the only zero-down payment guaranteed home loan program in the Nation with the lowest foreclosure rates in all categories of mortgage loans, and, finally, the seventh-largest life insurance enterprise in the country with a 96-percent customer satisfaction rating.

In the past, these services were either not available or affordable for the men and women who wore our country's uniforms, and, hence, the VA's mission to care for those who have borne the battle and for their spouses and orphans. This budget request is VA's plan for meeting our obligation to all veterans of all generations.

I will continue to do everything possible to ensure that we wisely use the funds that the Congress appropriates for us to improve the quality of life for our veterans innovatively and transparently so that you can see the decisions we make and how those funds are being invested.

PREPARED STATEMENT

Again, thank you for this opportunity to appear before the subcommittee and for your unwavering support. I look forward to your questions.

[The statement follows:]

PREPARED STATEMENT OF HON. ERIC K. SHINSEKI

Chairman Johnson, Ranking Member Kirk, distinguished members of the Senate Appropriations Committee, Subcommittee on Military Construction, Veterans Affairs and Related Agencies.

Thank you for the opportunity to present the President's fiscal year 2012 budget and fiscal year 2013 advance appropriations requests for the Department of Veterans Affairs (VA). Budget requests for this Department deliver the promises of Presidents and fulfill the obligations of the American people to those who have safeguarded us in times of war and peace.

Today, the Nation's military remains deployed overseas as it has during the last 9 years of major conflict. Our requirements have grown over the past 2 years as we addressed longstanding issues from past wars and watched the requirements for those fighting the current conflicts grow significantly. These needs will continue long after the last American combatant departs Iraq and Afghanistan. It is our intent to continue to uphold our obligations to our veterans when these conflicts have subsided, something that we have not always done in the past. Not upholding these obligations in the past has left at least one generation of veterans struggling in anonymity for decades. We, who sent them, owe them better.

VA has an obligation to track, communicate to stakeholders, and take decisive action to consistently meet the requirements of our Nation's veterans for care and services. We pay great attention to detail but there are many factors in the healthcare market that we cannot control. We must mitigate the risk inherent when requirements for veterans' care and services, and costs in the healthcare market, exceed our estimates. This request is the Department's plan for managing that risk and meeting our obligations to all veterans effectively, accountably, and efficiently.

The President's budget for fiscal year 2012 requests $132 billion—$62 billion in discretionary funds and $70 billion in mandatory funding. Our discretionary budget request represents an increase of $5.9 billion, or 10.6 percent, more than the fiscal year 2010 enacted level.

Our plans for fiscal years 2012 and 2013 pursue strategic goals we established 2 years ago to transform VA into an innovative, 21st century organization that is people-centric, results-driven, and forward-looking. These strategic goals seek to reverse in-effective decisionmaking, systematic inefficiency, and poor business practices in order to improve quality and accessibility to VA healthcare, benefits, and services; increase veteran satisfaction; raise readiness to serve and protect in a time of crisis; and improve VA internal management systems to successfully perform our mission. We seek to serve as a model of governance, and this budget is shaped to provide VA both the tools and the management structure to achieve that distinction.

For almost 146 years now, VA and its predecessor institutions have had the singular mission of caring for those who have "borne the battle" and their survivors. This is our only mission, and to do that well, we operate the largest integrated healthcare system in the country; the eighth-largest life insurance entity covering both Active-Duty members as well as enrolled veterans; a sizable education assistance program; a home mortgage enterprise which guarantees more than 1.4 million veterans' home loans with the lowest foreclosure rate in the Nation; and the largest national cemetery system, which continues to lead the country as a high-performing institution.

For 2 years now, we have disciplined ourselves to understand that successful execution of any strategic plan, especially one for a Department as large as ours, requires good stewardship of resources entrusted to us by the Congress. Every $1 counts, both in the current constrained fiscal environment and during less stressful times. Accountability and efficiency are behaviors consistent with our philosophy of leadership and management. The responsibility of caring for America's veterans on behalf of the American people demands unwavering commitment to effectiveness, accountability, and in the process, efficiency. In the past 2 years, we have established and created management systems, disciplines, processes, and initiatives that help us eliminate waste.

## STEWARDSHIP OF RESOURCES

VA has made great progress instilling accountability and disciplined processes by establishing our Project Management Accountability System (PMAS). This approach has created an information technology (IT) organization that can rapidly deliver technology to transform VA. PMAS is a disciplined approach to IT project development whereby we hold ourselves and our private-sector partners accountable for cost, schedule, and performance. In just 1 year, PMAS exceeded an 80-percent success rate of meeting customers' milestones.

In addition to PMAS, we adopted a new acquisition strategy to make more effective use of our IT resources. This new strategy, Transformation Twenty-One Total Technology (T4), will consolidate our IT requirements into 15 prime contracts, leveraging economies of scale to save both time and money and enable greater oversight and accountability. T4 also includes significant goals for subcontractors and other protections to make sure veteran-owned small businesses get a substantial share of the work. Seven of the 15 prime contracts are reserved for veteran-owned small businesses, and four of the seven are reserved for service-disabled small businesses.

In developing the fiscal year 2012 budget, VA used an innovative, Department-wide process to define and assess VA's capital portfolio. This process for strategic capital investment planning (SCIP) is a transformative tool enabling VA to deliver the highest quality of services by investing in the future and improving efficiency of operations. SCIP has captured the full extent of VA infrastructure and service gaps and developed both capital and noncapital solutions to address these gaps through 2021. SCIP also produced VA's first-ever Department-wide integrated and prioritized list of capital projects, which is being used to ensure that the most critical infrastructure needs are met, particularly in correcting safety, security, and seismic deficiencies, and creating consistent standards across the system.

The use of metrics to monitor and assess performance is another key strategy we employ to ensure the effective use of resources and accountability. For example, in November 2010, VA launched two online dashboards to offer transparency of the clinical performance of our healthcare system to the general public. First, VA's Linking Information Knowledge and Systems (LinKS) provides outcome measurement data in areas such as acute, intensive, and outpatient care. This allows management to assess a specific medical facility's performance against other facilities while, at

the same time, serving as a motivational tool to improve performance. The dashboard, Aspire, compiles data from VA's individual hospitals and hospital systems to measure performance against national private-sector benchmarks. Financial and performance metrics also provide the foundation for monthly performance reviews that are chaired by the Deputy Secretary. These monthly meetings play a vital role in monitoring performance throughout the Department, and are designed to ensure both operational efficiency and the achievement of key performance targets.

We also demonstrated our ongoing commitment to effective stewardship of our financial resources by obtaining our 12th consecutive unqualified (clean) audit opinion on VA's consolidated financial statements. In 2010, we were successful in remediating three of four longstanding material weaknesses, a 75-percent reduction in just 1 year. We also began implementation of a number of key management initiatives that will allow us to better serve veterans by getting the most out of our available resources:

—Reducing improper payments and improving operational efficiencies in our medical fee care program will result in estimated savings of $150 million in 2011. This includes continued expansion of the Consolidated Patient Account Centers to standardize VA's billing and collection activities.

—Implementing Medicare's standard payment rates will allow VA to better plan and redirect more funding into the provision of healthcare services. The estimated savings of this change in business practices in 2011 is $275 million.

—Consolidating contracting requirements, adopting strategic sourcing and other initiatives will reduce acquisition costs by an estimated $177 million in 2011.

The effective use of IT is critical to achieving efficient healthcare and benefits delivery systems for veterans. To accelerate the process for adjudicating disability claims for new service-connected presumptive conditions associated with exposure to Agent Orange, we implemented a new online claims application and processing system.

A recent independent study, which covered a 10-year period between 1997 and 2007, found that VA's health IT investment during the period was $4 billion, while savings were more than $7 billion.[1] More than 86 percent of the savings were due to the elimination of duplicated tests and reduced medical errors. The rest of the savings came from lower operating expenses and reduced workload. VA is continuing to modernize its electronic medical records to optimally support healthcare delivery and management in a variety of settings. This effort includes migrating the current computerized patient record system (CPRS) into a modern, Web-based electronic health record (EHR).

Advance appropriations for VA medical care require a multi-year approach to budget planning whereby 1 year builds off the previous year. This provides opportunities to more effectively use resources in a constrained fiscal environment as well as to update requirements.

MULTI-YEAR PLAN FOR MEDICAL CARE BUDGET

The fiscal year 2012 budget request for VA medical care of $50.9 billion is a net increase of $240 million more than the fiscal year 2012 advance appropriations request of $50.6 billion in the fiscal year 2011 budget. This is the result of an increase of $953 million associated with potential increased reliance on the VA healthcare system due to economic employment conditions, partially offset by a rescission of $713 million which reflects the cumulative impact of the statutory freeze on pay raises for Federal employees in fiscal years 2011 and 2012. The fiscal year 2013 request of advance appropriations is $52.5 billion, an increase of $1.7 billion more than the fiscal year 2012 budget request.

The establishment of a contingency fund of $953 million for medical care is requested in fiscal year 2012. These contingency funds would become available for obligation if the administration determines that additional costs, due to changes in economic conditions as estimated by VA's Enrollee Health Care Projection Model, materialize in 2012. This economic impact variable was incorporated into the model for the first time this year. Based on experience from 2010, the need for this fund will be carefully monitored in 2011 and 2012. This cautious approach recognizes the potential impact of economic conditions as estimated by the model to ensure funds are available to care for veterans, while acknowledging the uncertainty associated with the new methodology incorporated into the model estimates.

[1] "The Value From Investments in Health Information Technology at the U.S. Department of Veterans Affairs", Colene M. Byrne, Lauren M. Mercincavage, Eric C. Pan, Adam G. Vincent, Douglas S. Johnston, and Blackford Middleton, Health Aff, April 2010 29:4629–638.

Another key building block in developing fiscal years 2012 and 2013 budget requests for medical care is the use of unobligated balances, or carryover, from fiscal year 2011 to meet projected patient demand. This carryover of more than $1 billion, which includes savings from operational improvements, supports anticipated costs for providing medical care to veterans in fiscal years 2012 and 2013 and is factored into VA's request for appropriations. This is a vital component of our multi-year budget and any reductions in the amount of fiscal year 2011 projected carryover funding would require increased appropriations in fiscal years 2012 and 2013.

TRANSFORMING THE DEPARTMENT OF VETERANS AFFAIRS

The Department faces an increasingly challenging operating environment as a result of the changing population of veterans and their families and the new and more complex needs and expectations for their care and services. Transforming VA into a 21st-century organization involves a commitment to many broad challenges:

—to stay on the cutting edge of healthcare delivery;
—to lay the foundation for safe, secure, and authentic health record interoperability;
—to deliver excellent service for veterans who apply for disability and education benefits; and
—to create a modern, efficient, and customer-friendly interface that better-serves veterans.

In this journey, we are focusing on opportunities to improve our efficiency and effectiveness and the individual performance of our employees.

Our health informatics initiative is a foundational component for VA's transition from a medical model to a patient-centered model of care. The delivery of healthcare will be better tailored to the individual veteran, yet utilize treatment regimens validated through population studies. Veterans will receive fewer unnecessary tests and procedures and more standardized care based on best practices and empirical data.

The purpose of the VA Innovation Initiative (VAi2) is to identify, fund, and test new ideas from VA employees, academia, and the private sector. The focus is on improving access, quality, performance, and cost. VA remains committed to the best system of delivering quality care and benefits to veterans. VAi2 plays an important role by enabling the use of promising technologies in the design of cost-effective solutions. For example, the TBI Toolbox pilot, located at McGuire VA Medical Center in Richmond, Virginia, will test a software tool to standardize data gathered from brain injury treatments. The strategy will allow sharing of rapidly evolving treatment guidelines at VA polytrauma centers and Department of Defense (DOD) medical facilities, as well as patient progress and outcomes.

The fiscal year 2012 budget continues our focus on three key transformational priorities I established when I became Secretary:

—expanding access to benefits and services;
—reducing the claims backlog; and
—eliminating veteran homelessness by 2015.

These priorities address the most visible and urgent issues in VA.

EXPANDING ACCESS TO BENEFITS AND SERVICES

Expanding access to healthcare and benefits for underserved veterans is vital to VA's success in best-serving veterans of all eras.

The Veterans Relationship Management (VRM) initiative will provide veterans, their families, and survivors with direct, easy, and secure access to the full range of VA programs through an efficient and responsive multi-channel program, including phone and Web services. VRM will provide VA employees with up-to-date tools to better serve VA clients, and empower clients through enhanced self-service capabilities. Expanding the self-service capabilities of the eBenefits online portal is one of the early successes of the VRM program in 2010, and expansion of eBenefits functionality continues through quarterly releases and programs to engage new users.

VA also saw significant progress in expanding access to veterans. In July 2010, the Center for Women veterans sponsored a forum to highlight enhancements in VA services and benefits for women veterans which resulted in an information toolkit for advocates such as veteran service organizations to share with their constituencies.

Outreach was extended directly to women when, for the first time in 25 years, VA surveyed women veterans across the country to:

—identify in a national sample the current status, demographics, healthcare needs, and VA experiences of women veterans;

—determine how healthcare needs and barriers to VA healthcare differ among women veterans of different generations; and
—assess women veterans' healthcare preferences in order to address VA barriers and healthcare needs.

The interim report, released in summer 2010, informs policy and planning and provides a new baseline for program evaluation with regard to veterans' perceptions of VA health services. The final report will be released in spring 2011.

The Enhancing the Veteran Experience and Access to Healthcare Initiative will expand healthcare for veterans, including women and rural populations. Care alternatives will be created to meet these special population access needs, including the use of new technology. Where technology solutions safely permit, VA has already transitioned from inpatient to outpatient settings through the use of tele-medicine, in-home care, and other delivery innovations.

One area of success is our expansion of telehome health-based clinical services in rural areas, which increases access, and reduces avoidable travel for patients and clinicians. In 2010, the total average daily census in telehome health was 31,155. This program will continue to expand to an estimated average daily census of 50,147 in 2012, an increase of 60 percent more than 2010.

Through the Improve Veteran Mental Health Initiative more veterans will have access to the appropriate mental health services for which they are eligible, regardless of their geographic location. VA is leveraging the virtual environment with services such as the Veterans' Suicide Prevention Chat Line and real-time clinical video conferences.

## REDUCING THE CLAIMS BACKLOG

One of VA's highest priority goals is to eliminate the disability claims backlog by 2015 and ensure all veterans receive a quality decision (98-percent accuracy rate) in no more than 125 days. The Veterans Benefits Administration (VBA) is attacking the claims backlog through a focused and multi-pronged approach. At its core, our transformational approach relies on three pillars:

—a culture change inside VA to one that is centered on advocacy for veterans;
—collaborating with stakeholders to constantly improve our claims process using best practices and ideas; and
—deploying powerful 21st century IT solutions to simplify and improve claims processing for timely and accurate decisions the first time.

The Veterans Benefits Management System (VBMS) initiative is the cornerstone of VA's claims transformation strategy. It integrates a business transformation strategy to address process and people with a paperless claims processing system. Combining a paperless claims processing system with improved business processes is the key to eliminating the backlog and providing veterans with timely and quality decisions. The Virtual Regional Office, completed in May 2010, engaged employees and subject-matter experts to determine system specifications and business requirements for VBMS. The first VBMS pilot began in Providence in November 2010. Nationwide deployment of VBMS is expected to begin in 2012.

VA is encouraging veterans to file their Agent Orange-related claims through a new online claims application and processing system. Vietnam veterans are the first users of this convenient automated claims processing system, which guides them through Web-based menus to capture information and medical evidence for faster claims decisions. While the new system is currently limited to claims related to the new Agent Orange presumptive conditions of Parkinson's disease, ischemic heart disease, and hairy cell leukemia, we will expand it to include claims for other conditions.

VA also published the first set of streamlined forms capturing medical information essential to prompt evaluation of disability compensation and pension claims, and dozens more of these forms are in development for various disabilities. The content of these disability benefit questionnaires is being built into VA's own medical information system to guide in-house examinations. Veterans can provide them to private doctors as an evidence guide that will speed their claims decisions.

Another initiative to reduce the time needed to obtain private medical records utilizes a private contractor to retrieve the records from the provider, scan them into a digital format, and send them to VA through a secure transmission. This contract frees VA staff to focus on processing claims more quickly.

Additional claims transformation efforts deployed nationwide in 2010 include the Fully Developed Claims Initiative to promptly rate claims submitted with all required evidence and an initiative to proactively reach out to veterans via telephone to quickly resolve claims issues.

VA needs these innovative systems and initiatives to expedite claims processing as the number of claims continue to climb. The disability claims workload from returning war veterans, as well as from veterans of earlier periods, is increasing each year. Annual claims receipts increased 51 percent when comparing receipts from 2005–2010 (788,298–1,192,346). We anticipate claims receipts of nearly 1.5 million in 2011 (including new Agent Orange presumptive) and more than 1.3 million claims in 2012. The funding request in the President's budget for VBA is essential to meet the increasing workload and put VA on a path to achieve our ultimate goal of no claims over 125 days by 2015.

ELIMINATING VETERAN HOMELESSNESS

VA has an exceptionally strong track record in decreasing the number of homeless veterans. Six years ago, there were approximately 195,000 homeless veterans on any given night; today, there are about 75,600. VA uses a multifaceted approach by providing safe housing; outreach; educational opportunities; mental healthcare and treatment; support services; homeless prevention services; and opportunities to return to employment. The National Call Center for Homeless has received 13,000 calls since March 2010, and 18,000 veterans and families of veterans have been provided permanent housing through VA and Department of Housing and Urban Development (HUD) programs. These veterans were also provided with dedicated case managers and access to high-quality VA healthcare.

The Building Utilization Review and Repurpose (BURR) study is using VA's inventory of vacant/underutilized buildings to house homeless and at-risk veterans and their families, where practical. The Congress allocated $50 million to renovate unused VA buildings and VA has identified 94 sites with the potential to add approximately 6,300 units of housing through public/private ventures using VA's enhanced-use lease authority. This legislative authority is scheduled to lapse at the end of calendar year 2011. The administration remains committed to this important program, and a proposal to address the expiration will accompany the Department's legislative package submitted through the President's Program. In addition to helping reduce homelessness, vacant building reuse is being considered for housing for Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn ()veterans, polytrauma patients, assisted living, and seniors.

Homelessness is both a housing and healthcare issue, heavily burdened by depression and substance abuse. Our fiscal year 2012 budget plan also supports a comprehensive approach to eliminating veteran homelessness by making key investments in mental health programs.

The fiscal year 2012 budget includes $939 million for specific programs to prevent and reduce homelessness among veterans. This is an increase of 17.5 percent, or $140 million more than the fiscal year 2011 level of $799 million. This increase includes an additional $50.4 million to enhance case management for permanent housing solutions offered through the HUD–VA Supported Housing program. These funds are required to maintain the services that keep veterans rescued from homelessness sheltered; get the remaining men and women off the streets whom we have not reached in the past; and, prevent additional veterans from becoming homeless during a time of war and difficult economic conditions.

MENTAL HEALTH

The mental health of veterans is a more important issue now than ever before, as increasing numbers of veterans are diagnosed with mental health conditions, often coexisting with other medical problems. More than 1.2 million of the 5.2 million veterans seen in 2009 in VA had a mental health diagnosis. This represents about a 40-percent increase since 2004.

Veterans of Iraq and Afghanistan rely on mental healthcare from VA to a greater degree than earlier groups of veterans. Diagnosis of post-traumatic stress disorder (PTSD) is on the rise as the contemporary nature of warfare increases both the chance for injuries that affect mental health and the difficulties facing veterans upon their return home. In addition, mental health issues are often contributing factors to veterans' homelessness.

In order to address this challenge, VA has significantly invested in our mental healthcare workforce, hiring more than 6,000 new mental healthcare workers since 2005. In 2010, VA hired more than 1,500 clinicians to conduct screenings and provide treatment as well as trained more than 1,000 clinicians in evidenced-based practices. The Department has also established high standards for the provision of mental healthcare services through the recent publication of our Handbook on Uniform Mental Health Services in VA medical centers and clinics, and we have developed an integrated mental health plan with DOD to ensure better continuity of

care—especially for veterans of Iraq and Afghanistan. The fiscal year 2012 budget includes $6.2 billion for mental healthcare programs, an increase of $450 million, or 8 percent more than the fiscal year 2011 level of $5.7 billion.

MEDICAL CARE PROGRAM

We expect to provide medical care to more than 6.2 million unique patients in fiscal year 2012, a 1.4-percent increase more than fiscal year 2011. Among this community are nearly 536,000 veterans of Iraq and Afghanistan, an increase of more than 59,000 or 12.6 percent more than fiscal year 2011.

The fiscal year 2012 budget will support several new initiatives in addition to our efforts to eliminate veteran homelessness. For example, $344 million is provided for the activation of newly constructed medical facilities. In addition, we provide $208 million to implement provisions of the Caregivers and Veterans Omnibus Health Services Act and improve the quality of life for veterans and their families.

The fiscal year 2012 budget also includes operational improvements that will make VA more effective and efficient in this challenging fiscal and economic environment. VA is proposing $1.2 billion of operational improvements which include aligning fees that VA pays with Medicare rates, reducing and improving the administration of our fee-based care program, clinical staff realignments, reducing indirect medical and administrative support costs, and achieving significant acquisition improvements to increase our purchasing power.

Beginning in 2010, VHA embarked on a multi-year journey to enhance significantly the experience of veterans and their families in their interactions with VA while continuing to focus on quality and safety. This journey required the VHA to develop new models of healthcare that educated and empowered patients and their families, focused not only on the technical aspects of healthcare but also designed for a more holistic, veteran-centered system, with improved access and coordination of care. New Models of Healthcare is a portfolio of initiatives created to achieve these objectives. We are re-designing our systems around the needs of our patients and improving care coordination and virtual access through enhanced secure messaging, social networking, telehealth, and telephone access.

An essential component of this approach is transforming our primary care programs to increase our focus on health promotion, disease prevention, and chronic disease management through multidisciplinary teams. The new model of care will improve health outcomes and the care experience for our veterans and their families. The model will standardize healthcare policies, practices, and infrastructure to consistently prioritize veterans' healthcare over any other factor without increasing cost or adversely affecting the quality of care. This important initiative will enable VA to become a national leader in transforming primary care services to a medical home model of healthcare delivery that improves patient satisfaction, clinical quality, safety, and efficiencies. VA Tele-Health and the Home Care Model will develop a new generation of communication tools (i.e., social networking, micro-blogging, text messaging, and self-management groups) that VA will use to disseminate and collect critical information related to health benefits and other VA services.

VA is taking this historic step in redefining medical care for veterans with the adoption of a modern healthcare approach called Patient Aligned Care Team (PACT). PACT is VA's adaptation of the popular contemporary team-based model of healthcare known as Patient Centered Medical Home designed to provide continuous and coordinated care throughout a patient's lifetime.

MEDICAL RESEARCH

VA's many trailblazing research accomplishments are a source of great pride to our department and the Nation. Today's committed VA researchers are focusing on traumatic brain injury, PTSD, post-deployment health, women's health, and a host of other issues key to the well-being of our veterans. As one of the world's largest integrated healthcare systems, VA is uniquely positioned to not only conduct and fund research, but to develop solutions and implement them more quickly than other healthcare systems—turning hope into reality for veterans and all Americans.

VA's budget request for fiscal year 2012 includes $509 million for research, a decrease of $72 million less than the 2010 level. In addition, VA's research program will receive approximately $1.2 billion from medical care funding and Federal and non-Federal grants. These research funds will continue support for genomic medicine, point-of-care research, and medical informatics and IT. Genomic medicine, also referred to as personalized medicine, uses information on a patient's genetic makeup to tailor prevention and treatment for that individual. The Million Veteran Program invites users of the VA healthcare system nationwide to participate in a longi-

tudinal study with the aim of better understanding the relationship between genetic characteristics, behaviors, and environmental factors and veteran health.

To leverage data in the EHR, VA Informatics and Computing Infrastructure (VINCI) is creating a powerful and secure environment within the Austin Information Technology Center. This environment will allow VA researchers to access more easily a wide array of VHA databases using custom and off-the-shelf analytical tools. The Consortium for Healthcare Informatics Research (CHIR) will provide research access to patient information in VA's CPRS narrative text and laboratory reports. Together, VINCI and CHIR will allow data mining to accelerate findings and identify emerging trends. Ultimately, this critical work will lead to greater effectiveness of our medical system—improving value by assisting in the prevention and cure of disease.

## VETERAN BENEFITS

The fiscal year 2012 budget request for VBA is $2 billion, an increase of $330 million, or 19.5 percent, more than the fiscal year 2010 enacted level of $1.7 billion. This budget supports ongoing and new initiatives to reduce disability claims processing time, including development and implementation of further redesigned business processes. It funds an increase in full-time equivalents (FTE) of 716 more than fiscal year 2010 to 20,321 to assist in reducing the benefits claims backlog. It also supports the administration of expanded education benefits eligibility under the Post-9/11 GI Bill, which now includes benefits for noncollege degree programs, such as on-the-job training, flight training, and correspondence courses. In addition, the fiscal year 2012 budget request supports the following initiatives:

*Integrated Disability Evaluation System Program.*—The Integrated Disability Evaluation System (IDES) simplifies the process for disabled servicemembers transitioning to veteran status, improves the consistency of disability ratings, and improves customer satisfaction. An IDES claim is completed in an average of 309 days; 43 percent faster than in the legacy system. VA and DOD worked together to increase the number of sites for the IDES program from 21–27 in 2010. The six new sites are Fort Riley, Fort Benning, Fort Lewis, Fort Hood, Fort Bragg, and Portsmouth Naval Hospital, and VA and DOD will continue to expand the IDES program.

IDES is being expanded to provide Vocational Rehabilitation and Employment (VR&E) services to Active-Duty servicemembers transitioning through the IDES. These services range from a comprehensive rehabilitation evaluation to determine abilities, skills, and interests for employment purposes as well as support services to identify and maintain employment. The budget request includes $16.2 million for 110 FTE for the VR&E program to support IDES.

*Veterans Benefits Management System.*—In 2011, we will conduct two of three planned pilot programs to test the Veterans Benefits Management System (VBMS), the new paperless claims processing system. Each pilot will expand on the success of the first pilot by adding additional software components. In the fiscal year 2012 budget request for IT, we will invest $148 million to complete pilot testing and initiate a national rollout.

*VetSuccess on Campus.*—In July 2009, VA established a pilot program at the University of South Florida called VetSuccess on Campus to improve graduation rates by providing outreach and supportive services to veterans entering colleges and universities and ensuring that their health, education, and benefit needs are met. The program has since expanded to include an additional seven campuses, serving approximately 8,000 veterans. The campus vocational rehabilitation counselor and the vet center outreach coordinator liaise with school certifying officials, perform outreach, and communicate with veteran-students to ensure their health, education, and benefit needs are met. This will enable veterans to stay in college to complete their degrees and enter career employment. In addition, it provides veterans the skills necessary to gain employment after graduation, which can help prevent veteran homelessness. The fiscal year 2012 budget includes $1.1 million to expand the program to serve an additional 9,000 veteran students on nine campuses, more than doubling the size of the current program.

## NATIONAL CEMETERY ADMINISTRATION

The budget plan includes $250.9 million in operations and maintenance funding for the National Cemetery Administration (NCA). The funding will allow us to provide more than 89.8 percent of the veteran population a burial option within 75 miles of their residences by keeping existing national cemeteries open and establishing new State veterans cemeteries, as well as increasing outreach efforts.

VA expects to perform 115,500 interments in fiscal year 2012, a 1-percent increase more than fiscal year 2011. In fiscal year 2012, NCA will provide maintenance of 8,759 developed acres, 3 percent more than the fiscal year 2011 estimate, while 3,228,000, or 2.6 percent more, gravesites will be given perpetual care.

The budget request will allow NCA to maintain unprecedented levels of customer satisfaction. NCA achieved the top rating in the Nation four consecutive times on the prestigious American Customer Satisfaction Index (ACSI) established by the University of Michigan. ACSI is the only national, cross-industry measure of satisfaction in the United States. On the most recent 2010 survey and over the past decade, NCA's scores bested more than 100 Federal agencies and the Nation's top corporations including Ford, FedEx, and Coca Cola, to name a few. Our own internal surveys confirm this exceptional level of performance. For 2010, 98 percent of the survey respondents rated the appearance of national cemeteries as excellent; 95 percent rated the quality of service as excellent.

NCA has implemented innovative approaches to cemetery operations:

—the use of pre-placed crypts that preserve land and reduce operating costs;

—application of "water-wise" landscaping that conserves water and other resources; and

—installation of alternative energy products such as windmills and solar panels that supply power for facilities.

NCA has also utilized bio-based fuels that are homegrown and less damaging to the environment. NCA is developing an independent study of emerging burial practices throughout the world to inform its planning for the future.

Support for the Veterans Cemetery Grants Program continues in 2012 with $46 million to fund the highest priority veterans cemetery grant requests ready for award. In addition to State cemetery grants, NCA is engaged in discussions with tribal governments regarding the construction of veterans' cemeteries on their land and is awarding six such grants in 2011. The inclusion of tribal governments as grant recipients recognizes and empowers the authority of these groups to represent a unique group of veterans and respond to their needs.

## CAPITAL INFRASTRUCTURE

Congressional support of VA has resulted in 63 major construction projects funded in whole or, in part, since 2004. When combined with investments in our minor construction and major lease programs, this has contributed to a plant inventory which includes 5,541 owned facilities, 1,629 leased facilities, 155 million square feet of occupied space (owned and leased), and 33,718 acres of owned real property.

To best utilize resources, VA has reduced its inventory of owned vacant space by 34 percent, from 8.6 million square feet in 2001 to 5.7 million square feet in 2010. As discussed previously, we are using the BURR effort to reuse vacant space for homeless veterans and their families. BURR also identifies other potential reuses of vacant and underutilized space and land within VA's inventory such as assisted living, senior housing, and housing for veterans of Iraq and Afghanistan and their families. VA also houses homeless veterans in public and private ventures through enhanced-use leasing.

### *Major Construction*

The major construction request in fiscal year 2012 is $589.6 million in new budget authority. In addition, VA has been the beneficiary of a favorable construction market and, as a result, is able to reallocate $135.6 million from previously authorized and appropriated projects to accomplish additional project work—resulting in a total of $725.2 million for the major construction program. This reflects the Department's continued commitment to provide quality healthcare and benefits through improving its infrastructure to provide for modern, safe, and secure facilities for veterans. It includes seven ongoing medical facility projects (New Orleans, Denver, San Juan, St. Louis, Palo Alto, Bay Pines, and Seattle) and design for three new projects (Reno, West Los Angeles, and San Francisco) primarily focused on safety and security corrections. One cemetery expansion will be completed to maintain and improve burial service in Honolulu, Hawaii.

### *Minor Construction*

In fiscal year 2012, the minor construction request is $550.1 million. In support of the medical care and medical research programs, minor construction funds permit VA to realign critical services, make seismic corrections, improve patient safety, enhance access to healthcare and patient privacy, increase capacity for dental care, improve treatment of special emphasis programs, and expand our research capability. We also use minor construction funds to improve the appearance of our national

cemeteries. Further, minor construction resources will be used to comply with energy efficiency and sustainability design requirements.

*Greening the Department of Veterans Affairs*

The "greening VA" effort continues to be strong. There are 21 facilities Green Globe-certified and 4 facilities LEED-certified. We have completed energy efficiency benchmarking for 99 percent of VA-owned facilities and obtained the ENERGY STAR label for 30 VA sites since 2003. Electric meter installations were completed for 60 percent of targeted buildings and we are installing solar energy systems at 35 sites for a total capacity of 30 megawatts. VA has installed wind turbines at two sites, awarded two ground source heat pump projects, awarded five renewably fueled cogeneration projects, and completed one fuel cell project.

In fiscal year 2012, we plan to invest $27 million for solar photovoltaic projects, $51 million in energy infrastructure improvements, $21 million in renewably fueled cogeneration using biomass (wood waste) or biogas (waste methane), $1 million in sustainable building, $14 million for wind projects, and $10 million for alternative fueling projects and expansion of environmental management systems.

## INFORMATION TECHNOLOGY

IT is integral to the delivery of efficient and effective service to veterans. IT is not a supplementary function—it is key to the delivery of efficient, modern healthcare. The fiscal year 2012 budget includes $3.161 billion to support IT development, operations, and maintenance expenses. The fiscal year 2012 budget will fund the Department's highest IT priorities as well as information security programs, which protect privacy and provide secure IT operations across VA. Under our disciplined development program, Project Management Accountability System (PMAS), the delivery of customer software milestones exceeds 80 percent which is up from just 20 percent before the implementation of PMAS. The budget request will also fund systems that VA will develop and implement under the Caregivers and Veterans Omnibus Health Services Act of 2010.

In 2010, VA made the sound business decision to discontinue the Integrated Financial Accounting System and the data warehouse component of the Financial and Logistics Integrated Technology Enterprise. The Office of Information and Technology will fund other continuing projects such as Compensation and Pension Records Interchange (CAPRI) which offers VBA rating veteran service representatives and decision review officers help in building the rating decision. CAPRI does this by creating a more efficient means of requesting compensation and pension examinations and navigating existing patient records.

*Veterans Relationship Management*

The fiscal year 2012 IT budget for VRM is $108 million, and it will support continued development of the online portal as well as the development of customer relationship management capabilities.

## VIRTUAL LIFETIME ELECTRONIC RECORD

The Virtual Lifetime Electronic Record (VLER) is a Federal, interagency initiative to provide portability, accessibility, and complete health, benefits, and administrative data for every servicemember, veteran, and their beneficiaries. The goal of this major initiative is to establish the interoperability and communication environment necessary to facilitate the rapid exchange of patient and beneficiary information that will yield consolidated, coherent, and consistent access to electronic records between DOD, VA, and the private sector.

VLER will not create a new data record, but it will ensure availability of reliable data from the best possible source. The VLER health component of this initiative is in operation at two pilot sites with a plan to add nine more pilots this fiscal year. VLER will work closely with other major initiatives including VBMS and VRM. A total of $70 million in IT funds in 2012 is required to complete the effort and move to national production and deployment of initial VLER capabilities. The VLER partnership between VA and DOD will serve as a positive model for EHR interoperability in the country, which has been an administration priority.

## SUMMARY

VA is the second largest Federal department and has more than 300,000 employees. Among the many professions represented in the vast VA workforce are physicians, nurses, counselors, claims processors, cemetery groundskeepers, statisticians, engineers, architects, computer specialists, budget analysts, police, and educators—all working with the greatest determination to best serve all generations of vet-

erans. In addition, VA has approximately 140,000 volunteers serving veterans at our hospitals, vet centers, and cemeteries. There are things that they do that cannot be converted into dollar values—patience, dignity and respect for veterans, some of whom are heavily challenged by the memories of their wars.

As advocates for veterans and their families, VA is committed to providing the very best services. I will do everything possible to ensure that we wisely use the funds the Congress appropriates for VA to improve the quality of life for veterans and the efficiency of our operations—innovatively and transparently—as we deliver on the enduring promises of Presidents and the obligations of the American people to our veterans.

I am honored to present the President's fiscal year 2012 budget request for VA, and to represent all VA employees and the interests of those outside of VA, who share our commitment to veterans.

## CONTINGENCY FUNDS

Senator JOHNSON. Mr. Secretary, the budget includes a request for $953 million of contingency funds for medical services. As you described in your testimony, the need for this is due to the incorporation of current unemployment rates into the model, which may lead to greater demand for VA healthcare in fiscal year 2012. As you know, contingency funds are often viewed with skepticism by the Congress, especially in the House of Representatives. Can you explain the requirement and the rationale for this fund, and do you see this fund as a one-time only requirement?

Secretary SHINSEKI. Mr. Chairman, an important question.

As I think most members of the subcommittee know, we anticipate our requirements for healthcare through a process of modeling. It's called the Milliman model and it has been tuned to VA's factors.

Over the past 7 years, the model has gotten refined and quite precise to the point that it enjoys confidence in the Office of Management and Budget (OMB) and the Government Accountability Office, who have both looked at this. For the first time, the model has raised the requirement for an unemployment rate factor. It has never done that before. What we understand is because of the extended economic conditions, the model has raised this issue, indicating in 2012, it is likely we will need $953 million to address the unemployment rate factor.

While I have great confidence in the basic model because we have worked with it so closely over years, the unemployment rate factor is a first-year requirement. I do not have the history to be able to speak confidently about the accuracy of its prediction. The modelers advise me to pay attention because the model is usually correct.

I guess I could have tucked that money inside the budget. I thought it best to be transparent about it and demonstrate my concern that we are addressing a first-year new modeling requirement. We have scored our budget, put the $953 million into the budget, but set it aside, and allowed that to be called, unfortunately, a contingency fund, which I understand is a less than comfortable term. We have set it aside so that we cannot use it unless the unemployment rate factor does kick in, and I then have to take evidence of that and get a release from OMB. If that factor does not kick in, then the money goes back to the Department of the Treasury, or whatever unused portion remains goes back to the Treasury.

I would offer this was my effort to be transparent about my concern that this is a first year factor being introduced, and I wanted folks to understand that we are doing this. We scored it. We have done the right things. It is really risk mitigating as a decision that otherwise we would have to come and seek the Congress' support on a supplemental in 2012. I thought it was prudent to advance that decision in this way. I am open to any suggestions that the Congress deems appropriate.

CLAIMS PROCESSING

Senator JOHNSON. Mr. Secretary, you are to be commended for your effort to be transparent. But Senator Kirk and others will debate this.

Mr. Secretary, as you and I have discussed many times, the time it takes the VA to process a claim is a recurring complaint I have received from South Dakota. This subcommittee has provided the VA every dime it has asked for, and then some, to try and help you get a handle on the problem, yet the wait time is predicted to get even worse in fiscal year 2012. We are seeing the VA make significant strides in the past several years in shrinking the number of days veterans have to wait to see a doctor, yet on the benefits side, delays keep growing.

My first question is a very basic question. What is it about this process that makes processing claims in a timely fashion so difficult? And what is the comprehensive plan forward?

Secretary SHINSEKI. Mr. Chairman, just a little bit of history, when I arrived in 2009. For the first time our VBA, the people who do the claims processing who are good folks who come to work every day and try to do the right thing here—for the first time ever, they produced 977,000 claims decisions going out the door, and at the same time, there were 1 million claims arriving. The following year, 2010, we put 1 million claims decisions out the door and received in 1.2 million claims. We estimate this year, we are likely to receive 1.4–1.5 million claims.

To address this growth in the past, with great support from the Congress, our solutions have been to hire more people, and so every year we address the growth and have hired more people. Well, right now we have 14,000 people processing claims, and just looking at our most recent history, I can tell that hiring more people will give us an incremental improvement in production, but it will not get us to where we are knocking this backlog down. So we have to do something different.

And the issue here is automation. We have invested heavily in automation tools. The key one is being piloted today in Providence. It is the VBMS I talked about. We anticipate in 2012 VBMS is going to provide us with a tool that we can distribute nationwide and begin to use to go after the backlog. That is where we are in this process.

IT is the elephant in our house, and we have to get this done. This year in 2011, we provided an unprecedented increase for the folks in the VBA. We plussed them up by 27 percent, which is where a lot of the money that you have seen is affiliated with the increase in IT. We weighed an outcome on the 2011 decisions, and

hope the increase for tools in VBA will be sustained so we can deliver this tool.

That is where we are, and our plan is, as soon as these tools are available, to begin knocking down the backlog.

I came in 2009 with the intent of going to work on the backlog as the first priority. When I arrived, we had a brand new program called the Post-9/11 GI Bill, and all of my efforts had to go into getting the Post-9/11 GI Bill up and running, beginning in January 2009, because in August 2009 we had youngsters in classes going to school. It is a wonderful program; it is just that we had no automation tools at that time. Everything had to be done by hand. By the summer of that year, our efforts paid off. We had kids in school about 173,000 of them, put there, again, by working with about 6,500 different educational institutions. In the meantime, we built the automation tools that were going to change the environment for us. Today, we have in this program alone about 423,000 youngsters in school, all the processes, for the most part, are automated. It is because of what we went through, this sort of dark knight of the soul with the Post-9/11 GI Bill from full stop to up-and-running automation wise. I am confident that the investments we are making in VBMS are the right tool, and the payoff will be equally significant.

UNEMPLOYMENT

Senator JOHNSON. Senator Kirk.

Senator KIRK. Thank you, Mr. Chairman.

Is the unemployment factor in the fiscal year 2013 budget request as well?

Secretary SHINSEKI. I'm sorry, Senator.

Senator KIRK. Is the unemployment factor in the fiscal year 2013 budget request as well?

Secretary SHINSEKI. I am not sure I have a good answer for you on that.

Senator KIRK. Can you get back to us?

Secretary SHINSEKI. I will. I am happy to provide that.

Senator KIRK. I also want to make sure that the White House prediction of unemployment is your prediction, because my guess is the White House is going to predict over next year unemployment will fall dramatically. So I want to make sure left hand and right hand are actually talking to each other.

Secretary SHINSEKI. Yes. Again, the unemployment rate factor is an unknown for me, and I have put this in there because the model says so, and this is something I will have to deal with. I will have a better answer for you in 2012 when we see whether or not the unemployment rate factor kicks in. I am happy to provide that information.

CARRYOVER

Senator KIRK. Thank you.

And, of course, for you and Secretary Baker—as I understand it, when Secretary Baker came in as the Chief Information Officer in 2009, a significant portion of the Department's projects were behind schedule by more than 1 year and over budget by more than 50 percent. You halted the development of 44 projects and ulti-

mately canceled 12 of them. As a result of halting development on so many projects, the Department fell short of spending its money that the Congress appropriated in fiscal year 2009. As a result, the IT/VA account carried $676 million from fiscal year 2009 to fiscal year 2010. And, with all that carryover funding to supplement your fiscal year 2010 appropriation, you then carried another $675 million from fiscal year 2010 to fiscal year 2011.

In this time of budget constraints, and especially the pretty heavy scrutiny you are going to go through over in the House Appropriations Committee, I think the days of carrying more than $600 million are pretty much over. I think it would help us, Mr. Chairman, if we divided the IT account into three areas, and I hope our bill can do this—one line for salaries, one line for operations and maintenance, and one line for development so that we can keep a track of what has been a real problem child here. Is that possible to do?

Mr. BAKER. Thank you, Senator. We have looked just briefly at that. Clearly, we carry over primarily on the development side, but we also have a reason to carry over on the operations and maintenance side occasionally—equipment purchases and licenses and other things that may not get executed in August or September rolling into October or November. But as you identified, the primary reason for that carryover comes from development projects that we have slowed down or stopped.

I do not think that the proposal causes me any great angst. I think we lay those out in individual lines at this point in time, so I would certainly want to work with the staff on the implications of that.

Senator KIRK. Mr. Secretary, do you think—is there a way to have sort of, for lack of a better term, a Shinseki principle here that this IT effort is brought to bed by November of next year so that we make sure that we have full Shinseki management from start to finish exactly as we had for Stryker so that there is full accountability and no new personalities? If you screw up, you go back to the same boss.

Secretary SHINSEKI. I think in essence we have that now. It is called the Program Management Accountability System, and the key words in that are management accountability. This is Secretary Baker's creation.

Senator KIRK. My thinking is, is the deadline so that it all comes in while you are definitely with us?

Secretary SHINSEKI. We can certainly set it up.

Senator KIRK. Okay.

Secretary SHINSEKI. I would not speak about the deadlines, but the key words in the Program Management Accountability System are management accountability. Initially when you tighten the screws down and people have to explain why they are either over budget or over schedule, you get that initial delay in the execution and hence, the early carryover. I predict in 2011 and 2012 the carryover will be significantly less because we now have momentum and execution. Eighty percent of our projects are being executed at a very high standard, which was much less of the case in 2009 when I arrived.

GENERAL ADMINISTRATION

Senator KIRK. Okay. One other question. The Department's fiscal year 2012 request that proposes a record high $448 million for the VA's General Administration offices in Washington, DC, that is about $51 million higher than in fiscal years 2010 and 2011. The increase includes $23.5 million for an OMB initiative on reform for the Federal Government's acquisition force, but still it is a pretty high disconcerting request.

To put it in context, as recently as 2006, VA Central Office budget was just $275 million. That is a 63-percent increase for central offices just in 4 years.

Can you give us a compelling reason why the central administration costs so much so quickly?

Secretary SHINSEKI. Senator, I am happy to provide the details; I just do not have the details you are referring to today.

[The information was not available at press time.]

Let me just offer that part of that growth has been in the Office of the Secretary—primarily, a $834,000 increase over the fiscal year 2011 budget request. In reality, there is not another person working in my office this year that was not there last year. What I am trying to correct here, and again, I will chalk this up to transparency is in the past we have had a method of detailing people into the Office of the Secretary. They were paid elsewhere, but they actually worked in the Office of the Secretary. What I have tried to do is clean up the accounts so, if they work in the Office of the Secretary, they get paid there. It just made it clear where they were being employed.

Senator KIRK. Right.

Secretary SHINSEKI. That is part of what is here also. Acquisition is a Governmentwide initiative, and 50 percent of that funding is tied to that initiative. I am happy to provide the details and the remaining percentage.

Senator KIRK. Thank you.

Thank you, Mr. Chairman.

Senator JOHNSON. Before recognizing Senator Reed, I want to remind members that I am recognizing members in order of arrival.

Senator Reed.

CLAIMS BACKLOG

Senator REED. Thank you very much, Mr. Chairman, and thank you, Mr. Secretary, and your colleagues for your testimony today and for your service.

Both the chairman and Senator Kirk have raised very important questions about the IT funding. One other aspect that I would like to touch upon is, to what extent is that critical—the amount of money that you are carrying over—to addressing what we are all concerned about as a backlog in claims applications and processing? Another way to ask that if, in fact, this money is sort of recaptured or diverted, will that materially affect your ability to reduce significantly, and we hope eliminate, the claims backlog?

Secretary SHINSEKI. Senator, I am going to call on some of our administration leadership here because they really can describe the impact. But you know, we centralized IT because we wanted better

execution. When it was distributed throughout the Department, we had uneven decisions being made. We centralized it under an assistant secretary so we could have greater visibility and greater control.

The effect of what that creates is as though there is an IT entity. There is no IT entity. The IT is in medical, it is in benefits, and it is in cemeteries. Although you look over here and you see a fairly large program, the dots connect over here. Whenever we talk about reducing or reviewing the IT budget, those reductions end up impacting medical care and, most importantly, veterans' benefits where the backlog is what we are trying to take down. Even our cemeteries are tied to that.

I am happy to have Secretary Baker talk about the IT pieces, but I think it is important to ask the administrations what the impact to them is, if that is okay.

Senator REED. Go right ahead, please.

Mr. WALCOFF. Thank you, Senator. I am really glad that I have the opportunity to address this because it is something that I feel really strongly about.

As has been mentioned by several members, we have certainly gotten resources for people over the last several years. We have added a large number of people, yet we have not been able to accomplish what all of us want to accomplish, which is to eliminate this backlog.

Senator REED. For the benefit, can you identify your position?

Mr. WALCOFF. Okay, I am sorry. My name is Mike Walcoff. I am the Acting Under Secretary for Benefits.

Senator REED. Right.

Mr. WALCOFF. There has not been in the past the investment in technology in VBA that there really needed to be, particularly for this business line. If there is one reason that I would focus on for how we got to this point of a backlog, that would be it. What I would say is, that is being remedied in the fiscal year 2012 budget. It started in 2011, and it is being remedied in 2012 by the existence of two particular projects, one being the VBMS. This is the initiative that is going to take us away from a paper-laden, cumbersome system that has been the same as it was 50 years ago, to an electronic system, where everything is done through technology. It is going to allow us not only to produce more claims but, more importantly, I believe, increase our quality. Right now, our quality is at 84 percent. The Secretary has set a goal for us of 98 percent, a pretty significant increase.

What this system is going to do is by being rules-based, it is going to make it so when our rating specialists go in to work a claim, some of the issues that they have to decide, or the forks in the road that they came to in the past and possibly gone down the wrong road, this system is going to guide them to making the right decision on each of those decision points.

They will still be making the decision, but they will be greatly aided by the technology. It is extremely important that this go through, since it is really the key to allowing us to get over the hump of the situation where we keep getting more claims in than we complete, even though we keep increasing our production.

The second initiative is called the VRM system. The Secretary referred to it. This has to do with the methods that veterans use to interact with us. Right now, when a veteran wants to interact with us, basically he is confined to waiting until the normal business hours and calling us on the telephone. What the VRM initiative is going to do is enable a veteran to do a lot of things with self-service whenever he wants. If he wants, at 3 o'clock in the morning, to get up to change his address, instead of having to wait till the next morning to make a phone call, he can go in the system himself and do it. He can come in and check the status of his claim instead of having to call an agent the next day. He can change his direct deposit. There are all kinds of things that he can do with VRM that he can do with most other businesses he deals with that he has not been able to do with us before. It is extremely important.

The other question I get is, why are you so confident that these initiatives are going to be successful? I would tell you that my confidence is primarily because I have seen what technology has been able to do for the GI Bill. I think most of you remember we had some problems with the GI Bill in the beginning. We had to do a couple of things to work out of that, but the fact is we are in much better shape now. The main reason we are in such good shape now is because of the technology that was developed by our IT organization under Secretary Baker's leadership.

I appreciate the opportunity to answer. As you can tell, I am excited about this because it really is what is going to turn us around in the backlog area.

Senator REED. Thank you very much. My time has expired. But I think one of the—and I am no expert in business management, but private companies are able to reserve up front a significant amount of money for investment in new technologies, etc. One of the problems with our budgeting is everything is the same—personnel is the same, investing in technology is the same, etc. And this seems to me one of those examples where if we are able to reserve sufficient resources and invest them wisely, we will be able to save going forward and serve our veterans more effectively.

But thank you, gentlemen. Thank you, Mr. Chairman.

Senator JOHNSON. Senator Nelson.

## CONSTRUCTION

Senator NELSON. Thank you, Mr. Chairman.

Secretary Shinseki, let me just briefly say that under your leadership, I really believe the VA is making the kinds of gains that we are really taking care of the veterans in a much, much more responsible way, and in a way that is far more current in dealing with their needs. Obviously, there are commitments that need to be met, and we need to be as good at taking care of our veterans as we are at creating them. And I commend you for all your efforts and success in improvement.

The commitment made in last year's budget request to the Omaha VA hospital is very good news for thousands of veterans in Nebraska and western Iowa. The fiscal year 2011 budget request addresses the needs of the Omaha VA hospital by providing a plan and design money for what will be a much needed 21st century

healthcare facility. And I understand the plan and design of this facility can take as much as 18–24 months.

Mr. Secretary, as we are still operating under a continuing resolution, you have indicated in a previous conversation that the budget stalemate in Washington presents the possibility of a delay for the Omaha VA project. And if that is a possibility of the delay, perhaps maybe you can help me understand, as we have spoken privately, about what this might do to the construction and fulfilling the needs of veterans in that region of our country.

Secretary SHINSEKI. Certainly, Senator. I think, as you know, the project is to replace most of the existing campus. It will involve a new surgical suite, bed tower, intensive care unit, clinical and administrative services, and parking, so it is a significant project.

The request in the fiscal year 2011 budget request is for $56 million of design monies. We have within our capability to do advanced planning, and so we are in the process of doing advanced planning now. Schematic design as it is called; we expect it will be probably completed by July of this summer. We would then look for the design dollars to be awarded so we can go forward.

As long as the money arrives this year, we can go to the next phase, and we will then offer to the Congress the opportunity to allow us to carry that over for a 18–24 month period over the next few budget years. We would not be asking for new money, but it is the design monies that were awarded with the fiscal year 2011 budget. There may be a little delay, but we would be able to continue with the project.

Following that design, we expect construction documents and an offering for bids. It is a phase sequence. Right now, the $56 million is critical because it will allow us to begin the next phase. Any request for dollars will be based on what that design criteria ends up being. That is where we are, Senator.

Senator NELSON. And Dr. Pretzel, you are so very familiar with the Omaha facility. Can you give us an idea of how healthcare will be improved for veterans in—that will be accessing that hospital—that facility?

Dr. PETZEL. Thank you, Senator Nelson, I can.

There are several major problems at the facility right now that are going to be corrected. The heating, ventilation, and air conditioning systems are out of date and they cannot be improved. The operating room suites are very much undersized and not in appropriate relationship to the intensive care unit. We have difficulties with water seeping through the inner and outer walls, etc. There are multiple problems, Senator, that will be corrected by this within the facility. I think, most importantly, we will have a state-of-the-art new facility, state-of-the-art intensive care unit, and state-of-the-art operating rooms. We will be able to operate this facility much more efficiently than we are able to operate the Omaha facility now and do a better job of accommodating the needs of the veterans in Nebraska and western Iowa.

Senator NELSON. We have even experienced, as I recall, power outage in the middle of surgical operations, which have created more than a slight challenge for the healthcare of the veterans.

Dr. PETZEL. Yes, sir, that is true.

CEMETERIES

Senator NELSON. Let me ask first with the time I have left. The plans that are underway for the new veterans' cemetery in Satrapy County, and could you comment on—I know that cemeteries are under your direction. Could you let us know how things are going that way, Mr. Muro?

Mr. MURO. Thank you, Secretary. Thank you, Senator.

Right now, we have two sites that have risen to the top that we are reviewing, and once we get through the process, we will actually provide the Secretary with a recommended site that is the best for the area. That process is moving along very well. Once we get to that point, the offer to sell will be probably mid-summer, early summer. Then we will move forward and we will request funding in future years for construction. We have the funding to purchase and to design and to conduct all the studies we need at this point.

Senator NELSON. My time has expired, Mr. Chairman. Thank you.

And thank you, gentlemen, for your answers.

CONSTRUCTION

Senator JOHNSON. Senator Tester.

Senator TESTER. Thank you, Mr. Chairman. I want to thank you, Secretary Shinseki, and all the folks up at the table today. I appreciate your service. I will tell you that being on the Veterans Affairs Committee and on this subcommittee we get to see a lot of one another. I hope you appreciate that. I appreciate that, and I appreciate the work you do.

A couple of things: First of all, I want to thank you, Mr. Secretary, and Dr. Petzel for your work on a veterans clinic in Billings and because it is going to help a lot. It is going to help prevent rural veterans in Montana from traveling potentially 400 miles to get a clinic once this baby is built.

And I just wanted to talk about VA construction for 1 minute. I know these are tight times, but in your budget, how do you feel—the infrastructure portion of this budget, the VA construction portion of this budget. Does it meet the needs of our veterans? I am looking at it from a rural end in rural America, so if you would comment, I would appreciate that.

Secretary SHINSEKI. Certainly, Senator. As part of our review of our construction projects, one of the things we had to make sure of is we were focused on safety and security, both of veterans and the workforce. When you look at our projects, those projects that we are going to improve the safety and security of facilities migrate to the top, so there is a little bit of reordering. We are looking for new budget authority of $1.27 billion. It is not at the level that past budgets have been, but we have had to make some tough choices. But what it does do is provide balance in this budget. We support State cemetery grants out of this amount. State extended care grants also get attention. We did not zero those out to take care of just construction for VA; we understand that there is a partnership here between this Department and the States and being able to look after veterans.

Minor construction request, $550 million; major construction request, a total of $725 million. That is a combination of appropriations of $590 million plus $135 million that we are putting into the account because we have written tough contracts. We have competed them, and we get a better rate, because of the economic situation; a better price break on those returns. So, $135 million of efficiencies have been rolled back into our major construction account.

Major construction: 10 medical facility projects are in our priority list. As you know, we do partial funding as the requirements occur, so there are seven major medical facility projects underway, and then we are designing three new medical projects and one new cemetery project. It is a robust program.

Senator TESTER. You have got two wars, maybe more, who knows. Does it meet the needs of the demand of the folks you have got coming back from the theater converting into veterans in civilian life?

Secretary SHINSEKI. It does at this point.

MILEAGE REIMBURSEMENT

Senator TESTER. Okay, good.

Vet centers—first of all, thanks once again for getting us a couple more over the last few years and getting them opened up. They are going to be a big benefit to veterans, especially those with unseen injuries.

My question is, when you go to a clinic, there is a mileage reimbursement. If you go to a vet center, there is not. There is not a mileage reimbursement for the veterans, the disabled veterans. I have got a bill in to remedy that situation because I do not think it is right, and I will get into homelessness and mental illness here in a second. But the question is, what is your perspective? You probably have not had a chance to look at it because we just dropped it in recently. But what is your overall thoughts about potentially paying disabled veterans mileage reimbursement to get to vet centers? Go ahead.

Secretary SHINSEKI. Let me ask Dr. Petzel to comment on this.

Dr. PETZEL. Thank you, Mr. Secretary. Senator, that is an issue that we have been looking at.

Senator TESTER. Good.

Dr. PETZEL. We have been looking at that issue now over this last year and are in the process of developing a pilot to look at how this might be done and what it would cost.

Senator TESTER. Okay.

Dr. PETZEL. The issue is that in a fundamental way, because the vet centers are an alternate program, they are not viewed as being treatment. And the law, as you know, says——

Senator TESTER. Understand.

Dr. PETZEL [continuing]. That we reimburse for treatment. We would be delighted to work with you to try and find——

UNEMPLOYMENT

Senator TESTER. Yes. I would love to have that opportunity, and I think there is a lot of really, really, really—and that is why you guys—I know—I mean, there are a lot of them around, and rightfully so. With the unseen injuries we are getting out of Iraq and

Afghanistan, I think they are critically important. And if we are keeping people away, that would not be good either.

Real quick, and I just want your perspective on this. We talk about unemployment. What I am reading and what I am hearing is we have got two different kinds of unemployment in this country. We have got unemployment among general civilian population, and then we have got unemployment among our veterans in our civilian population. It is much, much, much higher. Do you have anything in this budget that will help remedy that?

Secretary SHINSEKI. We do see the difference, Senator, and this is what this contingency fund is intended to look at, and that is, the model tells us we are going to be facing this factor next year. It is a first year factor for us, but we have mitigated the risks.

Senator TESTER. Okay. Thank you. My time is up. I just want to close by saying one thing, Mr. Chairman. We have six people at the table up here. Three of them are confirmed and three of them are not. I think that is a sad statement. I think that you guys that are not confirmed hanging out there is ridiculous in an agency that is so critically important as we create more and more veterans, to have you guys sitting there and not being confirmed and you have been in that position for a while. So I appreciate your service, especially under those conditions.

Thank you.

Secretary SHINSEKI. Thank you, Senator.

EQUIPMENT STERILIZATION

Senator JOHNSON. Senator Blunt.

Senator BLUNT. Thank you, Chairman.

I am going to make one positive comment about what is happening at the VA and share one concern of mine. Then, I would like to ask a question about the John Cochran Division in St. Louis, regarding whether there is anything in either design or land acquisition that is included in this budget.

The positive comment is one I shared with you the other day, General Shinseki. The veterans' clinic in Branson, Missouri, in my old congressional district, and obviously a community I still represent, is likely unique in that at least a majority and probably a substantial majority of the people that visit this clinic only go there once. It is a real example of health IT at work. This is one of the areas where VA is clearly ahead of the overall medical environment. It is a good example of how much time, energy, and effort, you save and the better care that is available if doctors have access to an out-of-town patient's file. I believe that only about 25 percent of the people that visit the facility go multiple times. These are the people who are traveling. There are a number of doctors at the Branson Clinic. It is a substantially sized facility. VA is out there in a significant way showing how health IT works, and I'm appreciative.

The John Cochran Division in St. Louis, on the other hand, continues to have challenges. Last summer, they notified approximately 1,800 people who had used the dental clinic that the equipment had not been properly sterilized. It was a terrifying thing for all 1,800 people to get that notice.

Recently, a concern about surgical sterilization of equipment shut down the surgical part of the facility for a few days, both of which led to really low ratings from the consumers of their confidence in the facility. The last time I was there, I noticed that part of their problem is the age of the facility. My understanding is the John Cochran Division is at some position in land acquisition near the facility. I am wondering if there is anything in this budget that impacts either design or land acquisition there, or other things that might solve those problems at the John Cochran Division.

Secretary SHINSEKI. Let me call on Dr. Petzel.

Dr. PETZEL. Thank you, Mr. Secretary.

Senator Blunt, first of all, just briefly to describe what is happening and go back to what has happened.

Senator BLUNT. Well, I actually think I know what has happened. So, I do not have much time.

Dr. PETZEL. All right.

Senator BLUNT. Just tell me——

Dr. PETZEL. I will.

Senator BLUNT [continuing]. What we are going to do about it.

Dr. PETZEL. There is the project that you are aware of that is ongoing right now which is the redoing of the Sterile Processing Department (SPD)——

Senator BLUNT. The sterilization.

Dr. PETZEL [continuing]. The sterilization. That is going to be accomplished by July 2012. It involves creating a new area for SPD, and then renovating the present SPD and moving back into it.

We would have to get back to you about the specific things that are in the queue for St. Louis. There are a number of projects that are going to impact St. Louis in the future. We are just not prepared to be able to comment on that now.

Senator BLUNT. And I think one of them may involve Jefferson Barracks and the facility there.

Dr. PETZEL. That is another project. Jefferson Barracks is undergoing——

Senator BLUNT. Right.

Dr. PETZEL [continuing]. An extensive renovation.

Senator BLUNT. Yes.

Dr. PETZEL. Part of that is going to entail moving some of the spinal cord injury work that is done down at Jefferson Barracks up into the Cochran area where it is going to be surrounded by the intensive medical support that is needed.

There are also additional projects that are in the queue, and I would like to be able to get back to you——

Senator BLUNT. That would be great, Dr. Petzel——

Dr. PETZEL [continuing]. Post-hearing.

Senator BLUNT [continuing]. If you would do that. I would like to see what those projects are, and how any of them may be impacted by this budget, and the status of where both of those facilities are headed.

Dr. PETZEL. Yes, sir.

ARLINGTON CEMETERY

Senator BLUNT. Mr. Muro, I saw this morning again another report on concerns about Arlington. Every one of those reports, I am

sure, creates questions in the minds of families who now wonder how accurate the information is on the graves of those they care about. Can you give me a little update on what we are doing there?

Secretary SHINSEKI. Senator, may I——

Senator BLUNT. Certainly.

Secretary SHINSEKI [continuing]. Respond to that——

Senator BLUNT. Certainly.

Secretary SHINSEKI [continuing]. Because I saw the same article, and I took the opportunity to pick up the phone and call the Secretary of the Army, John McHugh.

Senator BLUNT. Yes.

Secretary SHINSEKI. Secretary McHugh assures me that he is working on this and is going to resolve these issues. At the same time, I have committed to him that all of our capabilities at VA are at his disposal. We have some of his people going through our training programs. We have provided some of our workforce there to augment his workforce, even as he is hiring folks. We are committed to helping him solve the issues he is wrestling with, and I think there will be a good outcome here. That is where we are.

Senator BLUNT. Is there a different arrangement for memorial affairs at Arlington than at some other veterans facilities? Are they all under the direct control of the service branches?

Secretary SHINSEKI. I will ask Mr. Muro to address this.

Mr. MURO. Are you wanting me to address how they control it at Arlington or at our cemetery?

Senator BLUNT. I am asking if it is different—is Arlington not considered one of your cemeteries. Is that right?

Mr. MURO. Correct, it is not one of ours.

ADVANCED APPROPRIATIONS

Senator BLUNT. Okay. Alright. Thank you, Secretary, for explaining your follow-up there to me. I think I am out of time, though I did want to ask just briefly your sense of the merits of the 2-year budgeting appropriation cycle that you are in. Just a brief sense of that because I think that is the direction we ought to try to head and many other areas, if we could.

Secretary SHINSEKI. Senator, I attribute this to the wisdom of the Congress in providing the advanced appropriations to this Department. I think we are one of very few departments to have this.

What it has allowed us to do is to get away from annual budgeting, sort of internal pressures where at the end of the year if you have any money left over, you are encouraged to spend it because you are going to give it up anyway. As I have said earlier, it may even be punitive, because your next year's budget is reduced by that amount.

What it has allowed us to do is to put in front of our leadership, the folks who bring to bear these ideas, the need to write good, tough contracts, which lets us be business oriented. We need to write good, tough contracts, and then compete them. You always get a better outcome. We look for an opportunity to have veterans who own small business, be part of this which is important to us because veterans hire veterans, and that addresses some of the other issues regarding veteran unemployment.

If we do those things, at the end of the year there will be savings. I have guaranteed leadership there is going to be savings, and I have invited them not to fall into the old bad habits, and spend at the end of the year. Let us collect savings and let me work with the Congress to explain what we have been able to accomplish, and then take those savings and reinvest in future budgets so we are buying down the requirement for new monies.

I know this is different. I know it is unusual. Some would say not a wise thing to do, but I just think this is the right thing to do with how we treat the monies we are entrusted with.

Out of this year, we have a full year's budget in healthcare. I can see at the end of this year a $1.1 billion in savings. We have taken $600 million of that and bought down our requirement in 2012. Our budget top line remains the same, but $600 million of that is how we have bought down the budget with our savings. In 2013, $500 million is a second piece of the $1.1 billion. We have bought down our requirement for new dollars, and I am anticipating now that this will allow us to save another $1 billion in 2011–2012 and another $1 billion in 2013, so that out of this 3-year cycle, I am looking for a $3 billion reinvestment opportunity. I just think this is the right way for us to approach our responsibilities.

Senator BLUNT. Thank you, Secretary.

Thank you, Chairman.

Senator JOHNSON. Senator Hoeven.

Senator HOEVEN. Thank you, Mr. Chairman.

Secretary Shinseki, I want to pick up kind of on that point that Senator Blunt was just talking about. I really appreciate your comments.

First, I want to start, though—thank you for your service on behalf of our veterans. It is such incredibly important work, and I truly appreciate it. We all do.

The second thing I want to mention is the VA medical facility in Fargo, North Dakota is outstanding. It is outstanding. You serve not only all of North Dakota, you serve a big chunk of Minnesota. You also serve into eastern Montana. I have toured it on a number of occasions. The facility is a good facility, and you are improving it, and your people there are caring people. And when I have gone through that facility and I have talked to veterans, they across the board have expressed appreciation for the quality of care and the quality of service that they get. I would encourage you, some time when it works for you, to come out. I would like to invite you to tour the facility. They are making some expansion improvements to it right now. But I think it is a clear demonstration of quality work on behalf of our great veterans, and I thank you for that.

Given the budget challenges we face, which are very, very real, and the incredible importance of taking care of our veterans, what ideas do you have—and I think you started down that trail on Senator Blunt's last question. What can we do to try to make these dollars go further when we talk about taking care of our veterans? What kind of things can we do to help? I mean, flexibility and the 2-year budget cycle. What ideas do you have that we can help make these dollars go further?

Secretary SHINSEKI. That is an excellent question, Senator. What we have tried to do over the past 2 years was change the culture

here in VA into a more business orientation, and we have done a lot, but we still have work to do inside our Department. Great people come to work every day trying to do the right thing, but if we are not synchronized and all looking at the same objectives, you won't have a tendency to get efficiency and accountability. Those things are then bumper stickers that you never really get delivery on.

The 2-year budget helps because it allows us to get away from the pressures of that year-to-year budget. Senator Kirk asked about the growth in the general account, which is the overhead. Well, suggesting that we ought to be more efficient does not usually result in efficiency. You have to put plans into place, you have to make clear objectives, and then you have to supervise, and that is the only way you get the right outcomes. A little bit of this issue is the growth and overhead that is of concern. I am happy to provide details, but it is the results we are looking at here.

If I can turn $3 billion in a 3-year span of budgets, I think there is other opportunity here that we would like to continue what we believe are the right behaviors and culture. Long after any of us are departed from this table, if we have put the right behaviors, the right disciplines, and processes in place, then this will be a new way of doing business in this Department. The support of this Congress would be crucial to our being able to deliver that system.

IT is the lifeblood here. Unfortunately, because we wanted to get control over IT, we centralized it over in Secretary Baker's account, so it looks like IT, but IT isn't an entity. It is everything we do over in healthcare. There is no separation between healthcare and medical IT, the same for benefits, and the same for cemeteries. My interest is being able to sustain the priorities that we have invested in so we can continue to deliver these returns.

BUDGET REQUIREMENTS

Senator HOEVEN. What are the key pressure points in terms of your budget and your ability to take care of veterans right now? You know, they are coming with post-traumatic stress disorder (PTSD), brain tissue injuries. We have been at war for more than 10 years. What are the pressing pressure points in terms of you taking care and meeting these needs of veterans vis-à-vis your budget constraints?

Secretary SHINSEKI. Well, it is the growth in the number of veterans coming to enroll with us. As I have indicated, in 2008, just before I arrived, we had 7.8 million veterans enrolled in healthcare; in 2012, that number is estimated to be 8.6 million, or about an 800,000 growth in population over 4 years. My expectation is that will continue to rise, and so, the investments in IT, in research and the quality of healthcare that we have underway today must continue.

The investments in IT for veterans' benefits decisions have to be sustained so that we can accept this increase in the number of claims being submitted. As I indicated, 1 million claims a year is not unusual. Now we expect it will be 1.4–1.5 million in this year alone.

I just think that the program we have described is a good one. The budget supports that. We have a new strategic program for

looking at our footprint with all of our facilities. We are trying to anticipate in the future where the veterans are going to populate, and how our current footprint is designed to meet that requirement. If it does not do that very well, how are we going to adjust over time? That is going to take a lot of work and a lot of engagement with the Congress to understand what that future plan will look like.

Senator HOEVEN. Mr. Chairman, if I might, one short follow-up to that.

Do you have the ability to move resources the way you need to provide care, and do you need significant more fixed asset or fixed facility to meet that population need you talked about, or can you focus your dollars into taking care of people?

Secretary SHINSEKI. You know, this is a great question because I am trying to answer the question looking forward.

Right now, I think we have the capability to respond in the way you have expressed. We do, however, from time-to-time, have to review our priorities, and that involves discussing them with the Congress. I am comfortable that we have a relationship and dialogue with the Congress so we can do that.

I believe that we have the tools at this point, Senator, and I am happy to come back and work with you and provide a better answer.

Senator HOEVEN. Thank you.

Senator JOHNSON. Senator Murkowski.

## HEALTHCARE REFERRAL

Senator MURKOWSKI. Thank you, Mr. Chairman.

Good morning, gentlemen.

Mr. Secretary, thank you for your service, for your commitment to our veterans, to all of you. You do an exceptional job by them.

Mr. Secretary, when we were here at this same hearing last year, I had an opportunity to discuss the practice that we see in Alaska of sending far too many of our veterans outside to Seattle for their care. And at the hearing last year, you told me—and I quote from the transcript—you said, "We are going to look at very closely why we would send a veteran on a 2,000-mile journey if there is competent, safe healthcare available close by." And then, Dr. Petzel, you also said, "It's one thing to come down for open heart surgery, which may be a super special kind of thing to do, but on the other hand, routine surgery that could be performed in Anchorage on a contract or in-fee basis probably ought to be looked at."

And as I mentioned to the Secretary in our meeting this week, which I appreciate, we are making some progress in certain areas. We are seeing that when it relates to veterans who are receiving chemotherapy treatment. We are now seeing that care provided locally.

The report from the VA inspector general in 2010 looked at the referral patterns over the years 2008 through 2009—591 veterans were required to travel to the lower 48 during that time period; 63 percent of those veterans resided in either Anchorage or the Matsu area, which is just outside of Anchorage. It is the home to the most sophisticated medical care that we have available in Alaska.

This week, Secretary, when we spoke, I shared with you the cases of two of our veterans, one a 79-year-old Anchorage veteran who was required to travel to Seattle for an orthopedic consult. The other one was a 74-year-old Anchorage veteran who had been directed to Seattle for goiter surgery. Both of these procedures could have been done, and when we asked the VA there in Anchorage, the standard response is, well, VA regulations provide that it must be done in a VA facility. Even if it is in Seattle, that is where the care has to be provided.

So I am going to take this opportunity again to ask, Mr. Secretary, why would we send a veteran on a 2,000-mile journey if there is competent, safe healthcare available close by? And Dr. Petzel, I would ask you if you stand by your statement from last year that if routine surgery can be performed in Anchorage, it ought to be provided by contract or a fee basis if it cannot be done in a VA facility. So, if we can just go back to that colloquy that we had last year.

Mr. Secretary.

Dr. PETZEL. Thank you, Mr. Secretary.

Senator Murkowski, you accurately did quote what I said back in the hearing last year. I was pleased when we reviewed this to see that the chemotherapy patients have been provided for in Anchorage. I am not pleased with the progress we have made. I think there are more things that could be done. Specifically, we would like to work with the Indian Health Service (IHS), the Native tribes, and the Air Force to see, like the Air Force and others who contract in the community, if we could do a consolidated bit of contracting to get a better price.

One of the issues has been the difficulty, with only one provider, of getting a contract that would be possible to work with. You have my promise that we are going to look much more carefully at being able to provide more of the care in the community. There will be an occasional thing, such as the example used before of open heart, where it might be in the——

Senator MURKOWSKI. Sure.

Dr. PETZEL [continuing]. Veteran's best interest to move. I stand by what I said before, and we will do a better job now of looking for alternatives in the community.

Senator MURKOWSKI. Okay. Well, we want to work with you.

Mr. Secretary.

Secretary SHINSEKI. Yes. Senator, let me just add, I think Dr. Petzel's response was significant. I would just say, as I am looking at the numbers I have, and the numbers you cited for 2010, these numbers are based on a 2009——

Senator MURKOWSKI. Right.

Secretary SHINSEKI [continuing]. Survey. For 2011, thus far, up till March, we are down to inpatient referrals to 26. Still, I would want to get into the 26 and then answer your question about why are we still sending folks. I do not have that detail, but from 200 or so down to 26, we are moving in the right direction.

And then in outpatient referrals, from the 2009 numbers of 600-plus, we are down to 278. So again, I would want to get in the details of the numbers.

I would also add that for non-VA care, fee-basis care, we are paying, about $4 billion a year, and that is going to go up significantly over the 2012–2013 time frame. We do have the ability to refer patients to the economy for civilian healthcare in communities when we are not able to provide it. I will work with Dr. Petzel and with you to have a better idea of what we are going to try to accomplish, set some objectives, and then let us work at them.

Senator MURKOWSKI. I appreciate you stating not only that you will work with us on this. Again, we recognize we have made some progress, but I think it is clear that we can and we must do more.

When you state you want to set some objectives, I appreciate that because you operate over there within the VA system from a very businesslike perspective using benchmarks and matrixes. I guess I would ask whether or not you can give me a matrix in terms of what we can anticipate or what we would hope to reduce the number of Alaska veterans that are being sent outside for care in this next fiscal year. If that is not something that you can give me today, maybe we can work on defining what that is.

Secretary SHINSEKI. I am not able to give you those numbers today, but I am happy to work with you and try to look forward and anticipate what the requirements are going to be, and at least have a common vision of what is the likely outcome.

Senator MURKOWSKI. I want to try to better understand. Again, we keep getting the message out of Anchorage VA that they are limited in their ability to provide for a level of flexibility if the regulations say we are stuck with it. Is it necessary for the Congress to provide you with any additional legislative authority in order to reduce the number of veterans that are sent outside for care, because I am getting a mixed message out of what is coming from the State and then what I hear from you and your clear willingness to work with us. But do we need more to ensure that there is no question but that that authority exists to provide that care locally?

Secretary SHINSEKI. I do not think at this point, Senator, we need any more assistance on this. Just let me get into it a little more deeply, and then come back and work with you on those outcomes. Then if you still feel that it is not sufficient, I am happy to work legislation with you.

Senator MURKOWSKI. I appreciate that, and I look forward to further defining how we address the care of the many veterans in our State. And I appreciate that.

Thank you, Mr. Chairman.

## NATIVE AMERICANS

Senator JOHNSON. I will permit a brief second round of questioning.

Secretary Shinseki, it remains important to me that we meet the unique needs of our Indian veterans. The Wagner State block was a groundbreaking partnership between the VA and IHS, and was long overdue. Mr. Secretary, now that the facility has been open for almost 1 year, how has cooperation between these two agencies been going, and does the VA plan on duplicating those efforts at other locations?

Secretary SHINSEKI. Mr. Chairman, the real hero here is Dr. Petzel, so I am going to let him provide the details.

Dr. PETZEL. Thank you, Mr. Secretary.

Senator Johnson, as you know, I am very familiar with the clinic in Wagner. It started a long time ago when I was a network director in Minneapolis and you and I shared the podium when we did the groundbreaking at——

Senator JOHNSON. Yes.

Dr. PETZEL [continuing]. That place. It was a precedent-setting effort. It is a VA-owned and operated clinic that sits on reservation land almost in the middle of the city of Wagner, and it is used by both American Indians and non-Indian veterans. It is an example that we would like to transmit to other parts of the country.

There have been a few others now, and we do have a number of clinics that are located proximate to reservations, but really not very many of them that are on reservations. Wagner has been a good example. It is operating. They have 370 patients enrolled. We think it is something that could be done in other parts of the country.

But the difficulty, and the big lesson learned there, was the fact it was very difficult to get the tribes, the IHS, the VA, and the local community all together on the same page deciding what to do. It took us actually 10 years to develop that. With the new memorandum of understanding (MOU) between the VA and the IHS, I am hoping that we can truncate that process and accomplish getting more of these clinics built in a much, much shorter period of time.

Senator JOHNSON. Do you have a concrete example of another VA–IHS combination?

Dr. PETZEL. Well, I do in South Dakota actually——

Senator JOHNSON. Yes.

Dr. PETZEL [continuing]. Where there has been a lot of progress made. We have a PTSD treatment program on the reservation at Pine Ridge. We do telehealth in both Rosebud and Pine Ridge in South Dakota. We have compensated work therapy programs at four Indian reservations in South Dakota. So there are a lot of examples of us being present on the reservations.

They are very remote, and they are underserved. There is just no doubt about the fact they are underserved. Just to point out the value and the importance of doing this, in South Dakota, 50 percent of the American Indian males are veterans.

Senator JOHNSON. Yes.

Dr. PETZEL. This is a warrior society. They participate in our military extensively, and I think we need to do a better job, quite frankly, of meeting their needs on the reservation.

Senator JOHNSON. Dr. Petzel, the healthcare reform bill authorized the IHS to enter into arrangements with the VA to share not just medical facilities, but also services. Are there plans underway to expand the sharing of healthcare services between the VA and IHS for Indian veterans in Wagner?

Dr. PETZEL. Senator, thank you, Mr. Secretary.

Senator, I cannot point to a specific thing that is going on in Wagner. I will go back and we can look and hopefully get back to you, as a post-hearing response. I do know that in a general sense across the country, once our attorneys in the IHS and the VA have agreed on what exactly the legislation means there will be substan-

tial opportunities to share services around the country, particularly for us to provide specialty care referral services for the IHS, and for us to, as you had mentioned earlier, co-locate some of our primary care and mental health facilities on reservations. I anticipate there will be a growth in our activity.

[The information was not available at press time.]

Senator JOHNSON. Mr. Secretary, what is the VA doing to improve access to VA healthcare and counseling on tribal lands?

Secretary SHINSEKI. Mr. Chairman, the basis for our approach here, and we are just at the inaugural stages of this, is we just signed an MOU with the IHS in October of last year, and that is now beginning to promulgate the activities that I think over time will deliver what Dr. Petzel is describing.

Just as an example here, the Wagner community-based outpatient clinic, as Dr. Petzel describes, is built on Yankton Sioux tribal lands, and it is bringing in more than just tribal veterans to that location. It is sized to fit about 700–800 veterans, and right now, the population is growing. We are about at the 370–400 mark, and there are lots of opportunity for growth. A lot of what will be required will be driven by the veterans who come there looking for services. Right now, we provide primary care, mental health services, and home-based primary care out of Wagner, as well as contracted specialty care. It is open 5 days a week, with normal working hours, so there is great access for veterans in the 10-county area that is serviced by Wagner.

INTEROPERABILITY

Senator JOHNSON. Senator Kirk.

Senator KIRK. Thank you, Mr. Chairman.

Back to health IT, especially medical records, what would be the difficulty in just saying across the board that all imagery are JPEGs, all documentation is Word documents, all databases are Access databases, so that we could just kill the proprietary thing right off the bat and have almost interoperability tomorrow?

Mr. BAKER. Thank you, Senator.

I think the one in there that I would be most concerned about would be specifying on the database side. Data representation is probably the toughest part of that one.

I would tell you that we are very focused on incorporating a lot more commercial-off-the-shelf—private-sector software, into what we do. It is our entire strategy.

Senator KIRK. Right.

Mr. BAKER. We recognize that we cannot build electronic health records (EHRs) at the rate that private sector does. If you look, we are blessed by the fact that we build and own one, and it is still one of the best EHR systems out there.

Our entire strategy going forward is to figure out how to bring in a lot more commercial-off-the-shelf into what we do and turn that into our entire strategy for EHRs.

Senator KIRK. What is wrong with just having you use the Department of Defense (DOD) stuff since they are generating veterans, or since you are a little bit larger than them right now, having them just surrender and using the VA standard? I mean, honestly.

Secretary SHINSEKI. I would just say that this has been a discussion that has been underway for 2 years now, and I think between the two of us, DOD understands that its current system capabilities are not going to be what they need in the future, so they are looking for a new direction.

We have a terrific EHR, but again, it is about 20 years in being. We are going to have to just also ensure the sustainability of that system. It is a great opportunity for both of us to put our heads together. Secretary Gates and I and our staffs met on the 17th of March to come to an agreement on a joint common platform. We have done that. Our staffs now have the responsibility by our next meeting in early May to come back with an implementation plan and the details of what that means. At that point, I am happy to come back and explain what our future will look like, and I expect that commercial-off-the-shelf will be very heavily represented.

Senator KIRK. The chairman and I were briefly talking. I think it would be great if he and I had you and Secretary Gates up here in mid-May to discuss how far you got and to have the Appropriations Committee propel you forward on defeating one side or the other, and just going with a common standard so that we are not inventing very much.

Secretary SHINSEKI. I am happy to come back and provide that update to the subcommittee. I cannot speak for Secretary Gates' calendar.

Senator KIRK. I was just talking with Tina. She said, you know, if we include Chairman Inouye and Chairman Cochran, it might propel attendance.

Secretary SHINSEKI. I think we have a good solution. This is what he and I have been working on for 2 years, and I think there is real potential for an outcome here that is different than anything that has been tried over the previous decades.

## CLAIMS ADJUDICATION

Senator KIRK. Great. I read the House transcript of your hearing pretty closely. In it, Chairman Culberson laid out an inspector general (IG) report that said callers to the VA had only a 49-percent chance of reaching an agent and getting correct information; that in claims processing, 23 percent of claims were processed incorrectly, and 50 percent of the compensation determinations were unnecessarily delayed. How have you responded to that IG report that the House Appropriations Committee focused so much attention on?

Secretary SHINSEKI. Mr. Walcoff.

Mr. WALCOFF. Senator, what you are actually quoting from are several different reports that the IG has done involving different parts of the VBA operation.

The reports on the quality of the claims adjudication, I would tell you that we recognize the fact that we have got to do something to improve the quality of our adjudications. That is why the technology part is so important because we recognize that just doing more claims at the current accuracy rate that we are doing is not the answer, we have got to make sure we improve our quality. We are working to do that.

Senator KIRK. I guess more worrying is the—only 49 percent chance of a caller——

Mr. WALCOFF. I am going to make a statement on that. We had some disagreement with them on the methodology they used to come up with that statistic. We did not concur with that fact the way that was quoted. Now, that being said, I will tell you that there is a lot of room for improvement in the quality of the call agent's work at our call centers. I am not going to deny that. We have done a lot of work since that report came out on reorganizing our training, having it more centralized, and having the individual call centers more accountable for how the training is being implemented. While I might not necessarily agree with that specific number, I will tell you that there is definitely room for improvement, and we are definitely trying to improve.

Senator KIRK. Last question, Mr. Chairman. The Congress appropriated a very large amount of money for health IT over at the Department of Health and Human Services (HHS). Can you describe how you have reached out to HHS who has what I would technically describe as a vast amount of money that we appropriated on the IT side?

Secretary SHINSEKI. Senator, we have been working with HHS. Part of the effort between Secretary Gates and I, first of all, we have two good EHRs, and our belief is that if we can merge our capabilities here and come out with this joint common platform in a way that is useful—if we are attentive to everyone else, not just the two of us, and have it be useful for HHS to use as a model as it looks forward, it will be cheaper and faster as well.

Senator KIRK. If I called Secretary Sebelius and said, how about the VA electronic record becoming the Medicare record, would she fight me?

Secretary SHINSEKI. I do not know the answer to that, but I can tell you that we have been working with her IT folks in this arena and keeping them abreast of our work with DOD.

Senator KIRK. Great.

Mr. Chairman, thank you.

Secretary SHINSEKI. May I just add, Mr. Chairman, to Mr. Walcoff's remarks? And the question is the IG report. I do not quarrel with the IG report. I think what you will see in our efforts to automate addresses most of those sort of observations in the report.

First of all, we have a growth in veterans coming to us, and that is accompanied by a growth in the amount of claims we are getting every year. The numbers are significant. Our ability to intervene here with just hiring more people, we have realized, at least I have realized in 2 years, you cannot hire and train fast enough because the quality you want comes with 20–30 years of claims processing. That is where the experience and the insights make for good, high-quality outcomes. Frankly, our quality employees with 2 or 3 years' experience cannot match that.

What we can match is if designing this rules-based engine that takes advantage of that 30-year set of experience and put it into the rules, then the 2- or 3-year experienced employee fills out the right data, pushes the button, and the computer can take over.

Senator KIRK. And by rules-based, you know, for people out in the public, this is like TurboTax.

Secretary SHINSEKI. It is.

Senator KIRK. It asks you a set of questions, and based on those answers, generates a tax return. This would ask a set of questions and would generate a disability determination.

Secretary SHINSEKI. Absolutely.

Senator KIRK. Yes.

Secretary SHINSEKI. Last year we produced 1 million claims in 2010. Just so there is clear sighting on what is involved in here, I would tell the subcommittee that 57.6 percent of those claims that we produced were reopened compensation claims, either a request for increase, a new condition that wanted us to take cognizance of, or a claim that had been previously denied. When you are in paper, every resubmission is a new start.

Senator KIRK. Right.

Secretary SHINSEKI. When you get that information in automation, 60 percent of the work is already done. It has already developed, and what you are doing is you are pulling that data up and reviewing it. That is why we want to get to this automation piece and why that is going to make a tremendous change in the way we have been doing business.

I would say of the phone calls that come in and cannot get a satisfactory answer, 50 percent of the calls are administrative like I want to change my number of beneficiaries; I want to change my mailing address; or I want to change my bank account. It is either those administrative calls or what is the status of my claim. It is sort of like that, with where is my FedEx package en route. All of this is through automation, and that is why the other project, VRM, is really the opportunity for a veteran to check in the system without having to make a phone call and wait for a call back or try to find someone with the right information. They can influence their interactions with us at a time and a place of their choosing, and that is why I think this automation solution in both these categories, claims and relationship management, hold the best opportunity for a major and significant change in how veterans interact with us and their satisfaction.

## RURAL VETERANS

Senator JOHNSON. Senator Murkowski, do you have any follow-up questions?

Senator MURKOWSKI. Just very quickly, Mr. Chairman, if I may. And this follows on your inquiry about working with the IHS.

Mr. Secretary, we have been talking for a number of years now about how we can better provide access for our Alaska Native veterans that are living in some pretty far flung parts of the State, some pretty remote areas, and how we can provide care for them closer to their homes, utilizing the Alaska Native Health System. And I appreciate your comment earlier about working together more collaboratively within IHS and with the tribes.

We have got a tribal liaison that has been created within the VA. I appreciate that. I really hope that we are able to see some positive action out of that. We will await that.

A couple of years ago, the Anchorage VA launched this pilot project to provide our rural veterans with a limited number of appointments at Native health facilities or community centers. We had an opportunity to discuss the independent report that came out August of last year, and it was not surprising that it was as big a disappointment, I think, as the report concludes. I had sent you a letter earlier saying that I was concerned about the design of this and how we were really going to be able to get the information out. What we learned was that 92 percent of the veterans surveyed indicated they had never heard of it. Many others said they did not use the pilot because they did not understand how it worked. Providers expressed their concerns that it was too limited in scope to provide for adequate level of care.

So we are through that. We are now where we are, and it does not seem like we have figured out what that solution is, how we provide for that better level of access to our rural veterans and more specifically, to our Alaska Native veterans.

Have we learned anything from this pilot project? What—and this is a very general question to you, but where do we go next in our efforts to provide care for our rural veterans?

Secretary SHINSEKI. Let me call on Dr. Petzel, and I will conclude.

Dr. PETZEL. Thank you, Mr. Secretary.

Senator Murkowski, you accurately described the results of that pilot. My personal feeling is that not all of the right things were done in terms of implementing that pilot. As you pointed out, for making people aware, and providing for a case manager coordinator to see that people actually used it and then follow through to see that the people that were eligible and in the area could actually use the clinic.

I think with the new MOU with the IHS and then the sharing arrangements that are described in that MOU, we have got an opportunity to go back and look at veterans using IHS clinics.

One of the issues that has arisen around the country, not just in Alaska, is the difficulty sometimes of having non-Native people use a facility that was dedicated to Natives. The fact that we have the interest on the part of the IHS at the national level in seeing that this occurs and that we do this, I think is going to go a long ways toward overcoming that resistance that we felt in some areas.

I think one of the immediate answers to your question is that we need to go back and re-look at and reinvigorate the idea of us using Native clinics for non-Native veterans, number one.

Number two is what I mentioned earlier, and that is a concerted effort at contracting for-fee care with the Air Force and the Alaska Native community. I just believe that we would provide a substantial amount of leverage if all three of us got together and looked for one contract with a network perhaps of providers that could better meet the needs of the Air Force, the VA, and the Native community.

You have got my promise that we are going to go back and look at trying to reinvigorate our using the Native clinics.

Secretary SHINSEKI. Senator, let me just conclude. I think if we were to look at the history of VA healthcare delivery, I think we would all recognize decades ago we had large hospitals, and

healthcare delivery was, come to the hospital and get your healthcare. In the past 15 years or so, some bright folks at VA decided to change that delivery model and to push from those hospitals out to the communities where veterans live. That is why we have community-based outpatient clinics and vet centers and mobile clinics, and so forth. I think that they were a good first step in trying to outreach to where the veteran populations were.

With the chairman's leadership, we have begun a rural program within VA, which takes that outreach to the next step with $250 million a year now for several years and that addresses the rural requirements, which is creating more opportunities for access to veterans.

I do not think what we have done is quite visualized what you are describing, and that is the longer reach to the highly rural areas where there are no roads, and it is difficult to get in to provide healthcare in the way we have traditionally provided it. That is why this MOU with the IHS is significant for us. I do not think we have maximized yet the capabilities here, and we probably need to take that vision—that next step—and codify some very specific objectives that we intend to accomplish here. I'm happy to do that with you and your staff and also with the chairman, who has been helpful here in the rural efforts.

Senator MURKOWSKI. I think the answer is clearly there. It is not as if we need to create or build VA facilities in every small community in America. That is not our answer. But where you do have systems, Federal healthcare systems, whether it is within the military, the DOD, or whether it is within IHS. Looking at it from the veteran's perspective, they are looking it and they are saying, "It is all Federal money here. I am a veteran. I am a Native. There ought to be some ability to work within this Federal system." It is not unlike what Senator Kirk has been talking about in terms of the electronic records. I think the average individual just cannot fathom that the VA does not connect with, speak with, DOD when it comes to the records of that individual who at one point in time was active military, then moved to the veteran. He has not changed. His health status has not changed, and yet his records do not travel with him. And it is not unlike being able to receive a level of care. You are working within different Federal health systems. There must be some better way that we can help to facilitate this. So again, I urge you as we look to these systems that we are setting up, whether it is our tribal liaisons to work within—between the VA and the IHS, the MOUs that we have. I think we need to get more aggressive because right now what happens is the promise that we have made to our veterans when it comes to healthcare seems to be only able to be fulfilled if you happen to live in the right part of the country. And that was not the promise. So we have got to be a little more flexible.

I think you have given the commitment to work with us, and I look forward to working with the chairman on this as well.

Thank you.

Secretary SHINSEKI. Senator, I would just conclude that the MOU we signed with the IHS is significant because we have begun to implement and to define what that really means. To this point, it includes pharmaceutical support, telehealth, homeless services,

cultural competence education, co-managing patients, physician cross-credentialing, and building of community-based outpatient clinics located near and even on tribal lands, which you know is a serious discussion, including transportation programs. We have begun to flush out what that MOU represented, and we just need to do that faster and better.

Senator MURKOWSKI. Thank you, Mr. Chairman.

## ADDITIONAL COMMITTEE QUESTIONS

Senator JOHNSON. I would like to thank the Secretary and those that accompanied him for appearing before this subcommittee. We look forward to working with you this year.

For the information of the members, questions for the record should be submitted to the subcommittee staff by the close of business on April 7.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

### QUESTIONS SUBMITTED BY SENATOR TIM JOHNSON

#### STRATEGIC CAPITAL INVESTMENT PLAN (10-YEAR PLAN)

*Question.* Mr. Secretary, the budget release was accompanied by the Department's Strategic Capital Investment Plan (SCIP). This plan outlines the Department of Veterans Affairs' (VA's) capital needs totaling between $55 and $60 billion over 10 years. Yet the VA is estimating it will spend a combined $720 million less on all of its construction programs in fiscal year 2012 than in fiscal year 2011.

How do you plan to achieve completion of the plan if budget requests continue to shrink?

Answer. The intent of the SCIP process is to provide, for the first time, a comprehensive and complete picture of VA's current inventory and outline the steps needed to enable VA to continually improve the delivery of benefits and services to veterans, their families, and their survivors. The fiscal year 2012 SCIP process identified $53-$65 billion in cost estimates over the course of the 10-year planning horizon.

The SCIP plan provides a rational, data-driven strategic framework to ensure all capital investments are focused on the most critical infrastructure needs first and funded in priority order. Safety and security is the criteria with the highest weight so projects that have the greatest impact in this area typically rank high and are included in our budget request. For example the highest ranking major construction projects address seismic issues at West Los Angeles and San Francisco, California, and Reno, Nevada. Furthermore, because the plan is data-driven and prioritizes projects based on identified needs, it ensures that VA uses the best value solutions to provide the highest quality benefits and services to veterans, their families, and survivors. The SCIP process also emphasizes the use of noncapital solutions to close gaps.

VA's fiscal year 2012 budget submission reflects choices that are made each year balancing the construction needs identified in the SCIP 10-year plan with other VA priorities. The advantage to the SCIP process is that the plan focuses resources on the highest capital asset priorities.

#### VETERANS BENEFITS MANAGEMENT SYSTEM

*Question.* Mr. Secretary, the Department has been in the process of developing its new paperless claims processing system—or Veterans Benefits Management System (VBMS)—for several years now. I understand that the first phase of VBMS is currently being tested at the VA in Providence, Rhode Island.

Can you tell us when you expect this system to be fully deployed?

Answer. The VBMS initiative involves business transformation efforts coupled with incremental technology releases to modernize the benefits adjudication process. There are three successive phases that are designed to develop and test process improvements and VBMS technology solutions in a production claims setting. Full na-

tional deployment is scheduled to begin in calendar year 2012, with completion projected in calendar year 2013.

As you have pointed out, VBMS is a critical part of your transformation initiative and seems to be one of the key pieces in your plan to eliminate the claims backlog and wait times.

*Question.* When can we expect to see tangible results from this system?

Answer. National deployment of VBMS will begin in calendar year 2012, with a staggered rollout to regional offices. Regional offices will deploy VBMS in groups of three to five offices. Offices should expect to see tangible results within 6–9 months postdeployment as they work through their existing inventory of paper-based claims and transition to the paperless environment. All offices in the Veterans Benefits Administration are projected to transition to VBMS by the end of calendar year 2013.

*Question.* In other words, when will this system actually lower the average time a vet has to wait for a claim to be processed?

Answer. As VBMS is deployed in small groups, processing times for those regional offices will be reduced as they work through the paper-based inventory and transition into the paperless environment. Veterans should expect to see a reduction in processing time within 6–9 months of their regional office of jurisdiction transitioning to VBMS. Ultimately, VBMS will provide the technology solution to achieve the goal of no veterans waiting more than 125 days for a quality decision on their claim.

*Question.* The VA was a pioneer in the development of electronic health records. However, the current system was designed in the 1980s and needs to be updated. The Department of Defense (DOD) is in the same boat. Over the years, this subcommittee has strongly encouraged both Departments to develop systems based on the same designs so that each aren't reinventing the wheel and doubling the cost to taxpayers.

Have you and Secretary Gates made a decision to pursue systems based on the same architecture?

Answer. Yes. In a meeting on May 2, 2011, Secretary Shinseki and Secretary Gates agreed to pursue a joint electronic health record.

*Question.* If not, why not, and if you have, when will development begin?

Answer. DOD Secretary Gates and VA Secretary Shinseki formally agreed on March 17, 2011, that the two Departments will work cooperatively toward a common electronic health record (iEHR). The iEHR is currently in the early planning phases. Planners have agreed to transform the team structure to best support the proposed governance model.

MEDICARE RATES

*Question.* Mr. Secretary, the VA is moving toward charging Medicare rates for certain services. I believe you are in the process of shifting to that model with dialysis right now and your budget assumes that you will also begin doing the same with ambulatory services in fiscal year 2012. There has been concern raised that moving to the lower Medicare rates could disrupt services for vets, especially in rural areas.

How do you plan to ensure that services for vets are not disrupted?

Answer. Dialysis is a service provided by VA as part of the veterans medical benefits package, and VA provides dialysis treatment within VA or by purchasing dialysis treatments from non-VA providers when such care is unavailable internally. VA is currently evaluating the risks associated to veteran access and VA costs if large provider groups decide to not accept veterans at the Centers for Medicare & Medicaid Services (CMS) rates. We believe many, if not most, providers will accept the CMS rates as these are the same rates reimbursed by other Federal payers. As a result we anticipate that there will be little to no impact on access to care for veterans. If we observe any negative impact new contractual agreements may be utilized to ensure our veterans continue to receive dialysis services closer to home. If contracts are required, VA will work in those specific areas to ensure no negative impact to access for these healthcare services.

BLACK HILLS HEALTH CARE SYSTEM

*Question.* Secretary Shinseki, 1 year ago, as rumors were swirling in South Dakota about changes to the Black Hills Health Care System, you assured me that before any final decisions were made, the VA would hold local town hall meetings to receive input from veterans and employees. I noticed that in the Department's SCIP, a project to build a new domiciliary in Rapid City, South Dakota, ranked No. 7. Such a project would have a significant impact on the Hot Springs VA campus and the Hot Springs community, where the domiciliary is located. I also understand

there are efforts underway to expand the Rapid City community-based outpatient center.

Secretary Shinseki, what is the VA's overall, long-term plan for the Black Hills Health Care System?

Answer. We are working to develop a feasible long-term plan for VA Black Hills that aligns services to veterans needs and locates more services closer to where the larger groups of veterans live. Demographic changes and migration of veterans, jobs, and other services to larger population centers in western South Dakota and northwestern Nebraska are forcing us to evaluate whether the current service configuration and locations of care are appropriate for optimal service to veterans both now and in the future. I can assure you that prior to any final decisions being made about Black Hills, veterans and stakeholder input will be received.

*Question.* When will this be communicated to the veterans and VA staff in the Black Hills?

Answer. No specific plan for re-configuration has been presented to the Secretary at this time. As options are developed, VA will ensure that all stakeholders, including veterans, Members of Congress, service organizations, employees, and the community are included in the discussion.

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## QUESTION SUBMITTED BY SENATOR MARY L. LANDRIEU

### CONTINGENCY FUND

*Question.* In the current fiscal environment, it is important that we look for inventive solutions to meet the needs of our growing veteran population while remaining fiscally responsible. We are also at a time when transparency is paramount in the way that we build and execute our budgets. I would like to commend Secretary Shinseki for innovative use of a contingency fund for veterans medical services.

Based on this backdrop, what are the trigger points that would warrant the use of the $940 million contingency fund?

Answer. Section 226 of the Administrative Provisions proposed in the 2012 President's budget states that:

". . . such funds shall only be available upon a determination by the Secretary of Veterans Affairs, with the concurrence of the Director of the Office of Management and Budget, that:

(a) The most recent data available for:

(1) National unemployment rates,

(2) Enrollees' utilization rates, and

(3) Obligations for Medical Services,

validates the economic conditions projected in the Enrollee Health Care Projection Model, and

(b) Additional funding is required to offset the impact of such factors."

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## QUESTIONS SUBMITTED BY SENATOR BEN NELSON

### MEDICAL CERTIFICATION AND EMPLOYMENT

*Question.* I recently met with a group of Iraq and Afghanistan veterans, two of whom were medically trained personnel who served on the front lines treating injured servicemembers. When they separated from the military, these veterans tried to continue their medical service in the community, but found that they lacked the State and local certifications to secure a job. Now both of these vets are unemployed and are faced with the decision to take 1 year or more, using their GI Bill benefits, to go through certification programs for skills they may already have. This seems to me to be a misutilization of two great resources: our combat veterans who have great training and real-world experience, and our GI Bill funds which may be paying for duplicate training. I understand it is not just our medical personnel who are facing this dilemma, this problem crosses multiple disciplines, including mechanics, firefighters, military police, etc.

Has the VA looked into this particular issue of specialized fields that require certification and what could perhaps be done for veterans to capitalize on their military training and service, so that we aren't duplicating money, time and training for the same specialties?

Answer. The Veterans Health Administration (VHA) staff is actively engaged with the Office of Personnel Management, and participated in a March 29, 2011, mini-summit on this issue. The purpose of the summit was to better understand the environment affecting veterans and transitioning servicemembers with medical back-

grounds seeking Federal nursing positions. Additionally, there was discussion regarding the creation of a career track to assist and guide these former medics and corpsmen who desire Federal nursing careers. Executives from VHA are assigned and actively working on subgroups to assist in developing strategies to improve recruitment into nursing and other allied health occupations. Federal agencies, colleges and universities, and other organizations are collaborating on these teams to identify potential solutions.

Qualification standards for nursing and some other occupations do require that candidates be licensed and/or credentialed to practice in their fields. Licensing standards traditionally rest with organizations external to VHA.

GI Bill benefits may be used to pay the costs associated with licensing and/or certification. If specific additional training is required to achieve a license or certification, the GI Bill could also be used for that training.

*Question.* What are we doing to help our veterans translate their military service into the civilian workforce?

Answer. The Department of Veterans Affairs (VA) will work with the Departments of Defense and Labor, accrediting agencies, and certifying bodies to ensure that the training and work experience that servicemembers receive will be acceptable for civilian employment.

At the present time, all schools and programs approved for VA education benefits must have processes in place to grant credit for prior training and experience. Each individual student's records must be evaluated, and credit granted as appropriate. Schools and programs make the final determination of whether a student will receive credit for prior training and experience.

Additionally, vocational rehabilitation and employment (VR&E) counselors meet individually with each veteran or servicemember seeking our services to assess their rehabilitation needs, set employment goals, and determine the most effective means to achieve successful outcomes.

As part of a comprehensive assessment, VR&E counselors conduct a transferable skills analysis to determine how an individual's previous education or experience may be used to qualify for employment in a similar occupation or related field. As a result of the assessment, the individual may be able to identify a shorter path to suitable employment that is compatible with his or her interests, aptitudes, and abilities. The individual and the VR&E counselor may develop a rehabilitation plan focused on VR&E's rapid access to employment track. VR&E provides employment assistance services that include short-term training or certification examinations, if needed to qualify for employment in the chosen occupation.

If the comprehensive assessment indicates that a longer period of education or training is needed to prepare for competitive employment, VR&E can help with transitional employment while the individual participates in VR&E's long-term services track. Depending on the individual's financial needs and the rate of pursuit of training, assistance may be provided through a work-study position or through job placement services focused on supplementing the monthly subsistence allowance with full-time or part-time work that would not interfere with completion of the rehabilitation plan.

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## QUESTIONS SUBMITTED BY SENATOR MARK PRYOR

### SAVINGS

*Question.* On March 1, 2011, the Government Accountability Office (GAO) released a report with recommendations to reduce duplication and save money across almost every Federal agency. On March 8, 2011, I sent letters to various agencies asking them to review the recommendations and report back to me regarding whether or not the agency agrees with GAO's findings and advise me of any actions taken or planned to be taken to address GAO's findings. I sent a letter to the Department of Veterans Affairs (VA) but have not gotten a response. GAO had three specific areas for the VA to look at.

Opportunities for the Department of Defense (DOD) and the VA to jointly modernize electronic health record systems.

Answer. The VA is responding to Senator Pryor's letter. In a meeting on May 2, 2011, Secretary Shinseki and Secretary Gates agreed to pursue a joint electronic health record. This is a complex, large-scale effort to modernize the health records systems of the two Departments in a manner that will allow for unprecedented amounts of data-sharing. This effort will produce enormous cost-savings for taxpayers over the long term through the use of large-scale efficiencies.

The integrated electronic health record (iEHR) when completed, will be a national model for capturing, storing, and sharing electronic health information, and will eliminate the costly duplicative medical testing that typically occurs as Active-Duty service personnel transition out of the military and over to VA healthcare facilities for medical care.

*Question.* The need to control drug costs and increase joint contracting when cost-effecting within the VA and DOD.

The VA and DOD currently have 88 joint national generic pharmaceutical contracts. The VA/DOD joint contracting subcommittee of the Federal Pharmacy Executive Steering Committee (FPESC) is focusing on increasing this number. There are currently 30 joint proposed contracts undergoing clinical review, and 8 joint pending contracts in various stages of contracting at the National Acquisition Center. It should be noted that because VA and DOD contract requirements can be extensive, a joint contract may actually decrease the number of bids and may result in no award.

Under the current formulary management systems, the opportunity for VA/DOD joint national contracting for pharmaceuticals is limited to generic drugs. Alteration of the structure of one or both formulary systems used by VA and DOD would be required in order to increase joint contracting opportunities for branded drugs; requiring legislative and/or regulatory changes. The FPESC subcommittee for joint contracting will continue to review both new and existing drugs for the possibility of joint contracting. The DOD and VA will continue to optimize joint contracts for generic drugs as joint contracts are currently in negotiations for previous blockbuster drugs such as losartan, tamsulosin, and ramipril.

*Question.* The need to improve cost-effectiveness and enhance services for transportation-disadvantaged persons. Have you had a chance to look at these recommendations? What are your thoughts on them?

Answer. The VA has included the VA Beneficiary Travel Program as part of its Health Care Efficiency Initiative. The program has been closely reviewed and areas for improvement identified with revised policy, procedures, and technical solutions currently being implemented that will result in improved efficiencies and cost-savings in the provision of this benefit.

VA recently initiated the Veterans Transportation Service (VTS) which seeks to overcome barriers to access, especially for veterans who are visually impaired, elderly, or immobilized due to disease or disability, and those living in rural and highly rural areas. VTS will increase transportation resources and options for all veterans, but also focus on improving efficiency of existing transportation resources through use of 21st century technology including ridesharing software and global positioning system (GPS) units. The program is established at four sites and is currently being implemented at an additional 22 facilities.

In addition to the long-standing collaborative effort with the Disabled American Veterans' Veterans Transportation Network that provides transport to veterans otherwise not eligible for beneficiary travel, VA is drafting regulations and procedural guidance to implement section 307 of Public Law 111–163, which authorized a program of grants for veterans service organizations to provide transportation services to highly rural veterans. This program will allow VA to support veterans service organization efforts to provide innovative means to transport veterans to healthcare. Once the program is operational, access to VA healthcare will increase for certain veterans currently experiencing barriers to VA healthcare due to transportation issues.

VA currently utilizes public and commercial transport services for both special mode (ambulance, wheelchair van, etc.) and common carrier (bus, taxi, airplane, train, boat, or ferry) transportation of eligible beneficiaries. Veterans integrated service networks and individual healthcare facilities are encouraged to enter into contracts for such services whenever possible. They also have authority to arrange services on an individual basis as required, and to reimburse for transport not previously authorized in certain circumstances. Field stations are encouraged to explore all available local, regional, State, and Federal transportation resources to provide services to eligible veterans at VA expense, as well as to assist veterans who do not meet beneficiary travel eligibility with potential transportation options.

In addition, as an agency member of United We Ride, VA is working with the Departments of Labor, Defense, and Transportation (among others) on a veterans initiative that will make it easier for veterans, military families, and other community members to learn about and arrange for locally available transportation services that connect them with work, education, healthcare, and other vital services.

HOMELESSNESS

*Question.* In the Department's fiscal year 2012 budget proposal, the administration requests a 17.5-percent increase in funding for programs that prevent and reduce homelessness among veterans. Part of this increase includes additional funding to better coordinate case management with the Department of Housing and Urban Development (HUD) through the HUD-Veterans Affairs Supported Housing (HUD–VASH) program. In the recently released GAO report on duplicative Government programs, GAO found that there are seven Federal agencies and more than 20 programs that address homelessness and that better coordination would minimize fragmentation and overlap.

How are you coordinating with the other agencies involved in addressing homelessness?

Answer. To eliminate homelessness among veterans, VA must coordinate these and other efforts with internal and external stakeholders. This strategy is a cornerstone of VA's Plan to End Homelessness Among Veterans. VA, along with other Federal partners and key stakeholders, has been an active participant in the planning and implementation of the U.S. Interagency Council on Homelessness's (USICH's) Federal Strategic Plan to Prevent and End Homelessness. Both VA and USICH plans require close partnerships with Federal, State, local, and tribal governments; faith-based, nonprofit, and private groups; outreach to veterans, people, and organizations providing services to veterans and the general public.

The strong partnership and coordination between VA and HUD is evidenced by the implementation and expansion of the HUD–VASH program and VA's participation in the 2011 Point in Time Count. The coordinated efforts between HUD, VA, and the Department of Labor (DOL) are also demonstrated in the HUD–VA Homelessness Prevention Pilot. This 3-year pilot is a partnership among VA, HUD, DOL, and local community agencies to provide housing assistance and supportive services to veterans returning/transferring from military service in the following locations:

—MacDill Air Force Base in Tampa, Florida;
—Camp Pendleton in San Diego, California;
—Fort Hood in Killeen, Texas;
—Fort Drum in Watertown, New York; and
—Joint Base Lewis-McChord near Tacoma, Washington.

At VA's National Forum on Homelessness Among Veterans Conference held in December 2010, each VA Medical Center (VAMC) was charged with holding a homeless veteran summit to confer with key partners in VA's efforts to end homelessness among veterans. Key partners of these local homeless veteran summits included local public housing authorities, Continuums of Care, HUD, DOL, State VA Departments, other key Federal, State, and local organizations. These meetings enabled VAMC leadership, staff, and local organizations to determine ways to more efficiently and effectively assist homeless veterans in accessing needed supportive services and suitable permanent housing in order to achieve and maintain stabilization. More than 170 local summits have been held since January 1, 2011. These summits have improved existing partnerships and assisted in building new partnerships.

Also at this conference, each VAMC was directed to participate in the 2011 Point in Time Count of the homeless held in January 2011, and in their local Continuum of Care. These directives have served to foster closer cooperation and collaboration between VA staff and community providers, including those in rural areas. These meetings will continue and further strengthen the ability of VA and other housing and service provider partners to effectively work together to end homelessness among veterans.

VA's Community Homelessness Assessment, Local Education and Networking Groups Program (CHALENG) is an innovative program designed to enhance the Continuum of Care for homeless veterans provided by the local VA and its surrounding community service agencies. The guiding principle behind Project CHALENG is that no single agency can provide the full spectrum of services required to help homeless veterans become productive members of society. Project CHALENG enhances coordinated services by bringing the VA together with community agencies and other Federal, State, and local governments who provide services to the homeless to raise awareness of homeless veterans' needs and to plan to meet those needs. The fiscal year 2009 CHALENG report indicates that local VAMCs have established almost 4,000 formal and informal collaborative agreements to serve homeless veterans.

RESEARCH

*Question.* The administration is requesting $509 million for medical and prosthetic research for fiscal year 2012, which is $72 million less than the 2010 levels.

I've had several veteran service organizations express concern regarding this drop in funding given the type and number of injuries we see sustained by returning veterans.

Can you address how your agency is addressing these concerns and the current efforts being made in these areas?

Answer. VA supports research projects based on merit review, and within the fiscal year 2012 budget, VA will support approximately 135 fewer projects from all services when compared with the fiscal year 2010 level. While there will be fewer projects, VA will continue to emphasize research on deployment and veteran-specific health issues. Areas of particular focus, such as gulf war veterans illnesses, women veterans, and mental health, will be preserved or increased, with the reductions being realized across the board in other areas.

VA's Office of Research and Development is adopting International Organization of Standardization (ISO) 9001 principles to increase management efficiencies in conducting clinical trials. The ISO is widely considered to be the standard for efficient and effective management systems. These improvements will further reduce the cost of performing clinical trials by reducing administrative costs and streamlining processes.

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## QUESTIONS SUBMITTED BY SENATOR MARK KIRK

### UNEMPLOYMENT RATE (MILLIMAN MODEL)

*Question.* Mr. Secretary, in last year's budget submission, the Department of Veterans Affairs (VA) requested $50.611 billion in advance appropriations for its medical care accounts in fiscal year 2012. However, the Department has since informed us that its budget estimates were based on 2008 actuarial data that did not account for a high unemployment rate. This year's request includes an additional $953 million for veterans' medical care, appropriated as a "Contingency Fund," if the Department needs additional resources due to high unemployment. However, we have no information about how unemployment has affected the fiscal year 2013 advance request.

Is the unemployment rate a factor in the 2013 advance request; if so, what is the assumed unemployment rate; and do you expect to submit a revised request for 2013 based on economic conditions?

Answer. Our actuarial model projection run for fiscal year 2013 assumed an unemployment rate of 7.4 percent. The budgetary impact of this economic factor on VA medical care for fiscal year 2013 will be considered during the development of the fiscal year 2013 President's budget, similar to the update of the fiscal year 2012 estimate in the fiscal year 2012 budget submission.

### CLAIMS PROCESSING

*Question.* Mr. Secretary, one of the biggest problems facing the Department is claims processing. Since 2007, this subcommittee has provided $277 million in additional resources for extra claims processors, plus $150 million in stimulus funding, in order to accelerate adjudications and reduce the disability claims backlog. Yet the stubborn fact remains that the Department hasn't been able to get its arms around this enormous problem. This budget predicts that average adjudication times and the disability claims backlog will be the worst they've ever been, with average adjudication times increasing from 165 days to 230 days in only 2 years due to the influx of Agent Orange claims.

What is it in this process that takes so much time? Do you need legislative fixes? New regulations? Or is it simply that the Department hasn't yet been able to balance new technologies with its claims processing method?

Answer. The number of disability claims received continues to increase at record pace. This challenge is due to a number of factors, including:

—The addition of three presumptive conditions associated with exposure to Agent Orange;
—VA's successful outreach efforts;
—The return of servicemembers from Iraq and Afghanistan;
—More complex medical issues; and
—An increasing number of issues claimed by each veteran.

VA is confident that our transformation efforts will enable us to eliminate the claims backlog in 2015. The cornerstone of VA's claims transformation strategy is the Veterans Benefits Management System (VBMS). VBMS integrates a business transformation strategy to address process and people with a paperless claims processing system. Combining a paperless claims processing system with improved busi-

ness processes is the key to eliminating the backlog and providing veterans with timely and quality decisions.

*Question.* I understand that the Department hopes to roll out the VBMS to revolutionize the disability benefits claims process. But given the Government's history of developing IT projects, I just want to be sure we're not pinning all our hopes on one IT program to solve all of these problems. Is that what we're doing?

Answer. We believe that VBMS will be a valuable tool in eliminating the backlog starting in 2012. Evolving to a paperless process is essential, but we are aggressively pursuing our claims transformation initiatives right now, in order to lay the technological and business transformation groundwork to streamline claims processing and eliminate the claims backlog. Our end goal is a smart, paperless, electronic claims processing system.

While we work to develop the paperless system, we are making immediate changes to improve the efficiency of our business activities. New calculators for certain medical conditions guide claims decisionmakers with intelligent algorithms similar to tax preparation software or through simple spreadsheet buttons and drop-down menus. A growing body of evidence-gathering tools, called disability benefits questionnaires, brings new efficiencies to collection of medical information needed to rate each claim. The Fully Developed Claims Program speeds the decision process by empowering veterans and helping them submit claims that are ready for VA decision as soon as they are received.

*Question.* Are you looking at making it easier for veterans to clearly know what documentation he or she needs to submit to the VA when making a particular disability claim, and thereby simplifying the back-and-forth between the veteran and the Department that consumes much of the adjudication process?

Answer. VA has implemented several initiatives designed to inform and help veterans with their claim submissions. Three disability benefits questionnaires are available online, and more on the way, for veterans to provide to their private or VHA physician. Each disability benefits questionnaire is for a specific condition, and the questions guide the physician's response to ensure we receive the data we need to make a decision on the veteran's claim.

VA also offers an online application system, Veterans Online Application, that is accessible through e-Benefits and the VA Web site. The application system allows a veteran to file a claim for compensation, pension, education, or vocational rehabilitation and employment benefits.

VA implemented the Fully Developed Claims Program, partnering with veterans service organizations to assist veterans in submitting everything VA needs at the time of their application. VA is working to improve its processes with a goal of completing fully developed claims within 90 days of receipt.

In addition, the Veterans Claims Assistance Act requires VA to notify all claimants of the information and evidence necessary to substantiate their claims, which portion of the information and evidence VA will try to obtain for them, and which portion they are expected to provide.

NORTH CHICAGO

*Question.* Mr. Secretary, one of my biggest priorities since I entered the Congress has been the Captain James A. Lovell Federal Health Care Center (FHCC), a first-of-its-kind partnership between the VA and the Department of Defense (DOD) to fully integrate all medical care into a single mission. The facility not only integrates the two facilities, but also serves 40,000 Navy recruits, 67,000 military and retiree beneficiaries each year, and veterans throughout northern Illinois and southern Wisconsin. I look forward to working with you to make sure this first-of-its-kind partnership with the DOD is a success.

Can you provide me with an update on this facility, how has integration gone thus far, and do you view it initially as a success?

Answer. As of May 5, 2011, after 216 days, the James A. Lovell FHCC continues to work through the change management processes as the new organization evolves. The FHCC is currently meeting the needs of all beneficiaries. Because there are no shortages of clinicians, healthcare providers at the FHCC currently serve all beneficiaries not requiring urgent or emergent care on a first come, first served basis. As of April 2011, the facility does not have a wait list for patient access. The close monitoring of Navy recruit medical readiness ensures we are able to maintain the "pipeline to the fleet" of enlisted sailors. Integration is completed in a number of areas and the new ambulatory care facility is fully operational. The joint governance structure was fully implemented on October 1, 2010. Information management/information technology (IT) efforts are beginning to yield successful results, in particular in joint registration and single medical sign on for both DOD and VA record sys-

tems. Successes and lessons learned from FHCC are helping to contribute the way forward of an integrated electronic health record (iEHR) maximizing joint interoperability of records and care for the DOD and VA beneficiaries.

The FHCC is continuing the development of an integrated budgeting and financial reconciliation process. For fiscal year 2011 through fiscal year 2013, the FHCC plans to use historical financial data to budget and determine the amount each department will transfer to the Joint Fund and expects to manually conduct the year-end reconciliation process. By fiscal year 2014, the FHCC plans to have an automated year-end financial data reconciliation process. However, as of April 2011, the integration of fiscal authority had not been fully implemented because there was no legal authority to transfer appropriations to the Joint Fund. For fiscal year 2011, the FHCC is being funded through an alternative funding mechanism (resource-sharing agreement) established by the executive agreement. However, with funding now authorized for transfer to the Joint Fund, the FHCC will be funded through the Joint Fund beginning July 1, 2011.

In the workforce management and personnel integration area, 469 DOD civilian personnel were transferred to VA as of October 10, 2010—the deadline established in the executive agreement. FHCC completed integration of the staff training programs through an integrated education department, as stated in the executive agreement. One component of staff education is the maintenance of medical and dental skills for the FHCC's Navy healthcare providers. One of the benefits of the integration is that dental school graduates obtaining advanced education in the Navy can see Veteran patients while completing their residencies and have opportunities to be exposed to different dental conditions than those normally seen in the generally younger and healthier recruit population. This is especially helpful training for dentists who will be placed on ships, where they are often the only on-site dentist. There is a similar benefit for healthcare professionals providing inpatient care.

GAO is conducting a study of the Lovell FHCC due to the Congress this summer and DOD contracted the Institute of Medicine to evaluate whether the integrated DOD/VA healthcare facility in North Chicago is more beneficial to DOD and VA than their independent facilities in serving the needs of their eligible populations. The Institute of Medicine is expected to evaluate health outcomes, patient satisfaction, provider satisfaction, quality of care, and costs of care and prepare a written report with findings, conclusions, and recommendations for DOD and VA that will be available to the general public in 2012.

*Question.* As I understand it, the VA and the DOD have pledged $100 million for an IT project at this unique facility to allow their medical software communicate with one another. Can you provide me with an update on that project?

Answer. In a meeting on May 2, 2011, Secretary Shinseki and Secretary Gates agreed to move forward with joint solutions for the remaining capabilities not yet delivered at the Captain James A. Lovell FHCC. The refined implementation will be informed by the work being done on the iEHR Way Ahead.

The current status of the IT projects is:

—Medical single sign-on with context management:
  —Production: December 13, 2010;
  —Current status: Sustainment;
—Single patient registration:
  —Production: December 13, 2010;
  —Current status: Maintenance and enhancements;
—Pharmacy (iEHR):
  —Current status: On-hold pending iEHR business policy review: July 7, 2011;
—Laboratory and radiology orders:
  —Production Limited/Controlled: March 2011;
  —Current status:
    —Radiology:
      —Production: Projected to go live June 15, 2011;
      —Current status: Preparing for live production;
    —Laboratory:
      —Production: Projected full production July 15, 2011;
      —Current status: Currently in limited production to a controlled number of physicians.

*Question.* That brings to me a larger question about joint collaboration between the DOD and the VA. As I understand it, each Department is in the process of developing its own electronic medical record at a cost of billions of dollars to taxpayers. However, GAO recently reported the departments lack the mechanisms to jointly address collaborative opportunities for common development. I want to be sure that DOD and VA aren't on separate, parallel tracks that duplicate costs.

Are the Departments working together on these massive efforts, and has everyone agreed to build to the same standards, and where have you identified potential economies of scale for joint development?

Answer. Yes. The VA and the DOD are working together to jointly develop an electronic health record that will provide information to both agencies about our soldiers, sailors, airmen, and veterans. Both agencies have agreed to consolidate data where applicable, use common services, and develop a joint platform in order to realize economies of scale.

*Question.* One approach that would make sense to me is for the Congress to require each Cabinet Secretary to certify that all new development on an electronic medical record is both interoperable between VA and DOD and that neither Department is reinventing the wheel. Do you have any response to that potential approach?

Answer. The Secretaries of VA and DOD agreed to meet on a continuous basis to monitor and discuss the progress made on the joint electronic health record being developed by their staff. These recurring meetings will afford the Secretaries to continue to move forward with joint solutions for the remaining capabilities not yet delivered at the Captain James A. Lovell FHCC and to discuss and remove any impediments that stand in the way of making progress.

STAFF OFFICES

*Question.* Mr. Secretary, as you well know, this country faces record-high deficits and debt, and we are now entering a period of fiscal restraint and budget cuts.

So I couldn't help but notice that the Department's fiscal year 2012 budget request proposes a record-high amount of $448 million for the VA's General Administration offices in Washington, DC. This amount is $51 million higher than in fiscal years 2010 and 2011. Now I understand that this increase includes a $23.6 million Office of Management and Budget initiative to reform the Federal Government's acquisition workforce, but I find this specific request disconcerting.

To put this in some context, as recently as 2006, funding for VA central offices was $275 million. That's a 63-percent increase in the budgets for VA central offices since 2006.

*Question.* Can you give us a compelling reason why these offices should be increased by $51 million over last year when almost all other agencies and Departments across our Government are taking painful budget cuts, particularly in their administrative overhead in Washington, DC?

Answer. Much of this staff office increase is driven by new capabilities necessary to oversee and enhance enterprise-wide performance in critical areas such as safety and security, acquisitions, human capital and financial management. For example, the fiscal year 2012 request includes $23.6 million to increase the capacity and capability of VA's acquisition workforce. In addition, $2.9 million will be invested to enhance VA's Emergency Preparedness capability and to fully implement Homeland Security Presidential Directive 12. This will lead to improvements in veteran and employee safety and greater protection of VA facilities. Overall, staff office capability seeks greater enterprise-wide efficiency, accountability, and effectiveness.

*Question.* Putting aside the $23.6 million Office of Management and Budget initiative to reform the Federal Government's acquisition workforce, can you please provide us with the impacts if General Administration remains at the fiscal year 2010 enacted level of $397.5 million?

Answer. The fiscal year 2012 budget supports the establishment of a corporate management infrastructure that will lead to greater accountability, efficiency, and effectiveness throughout VA. Some of the major investments that would not be supported at fiscal year 2010 levels include the following:

—Enhance VA's Emergency Preparedness capability and full implementation of Homeland Security Presidential Directive 12 (HSPD–12) initiated August 27, 2004. This makes facilities safer for veterans and employees.

—Increase the use of the Alternative Dispute Resolution (ADR) program which will lead to a safer work environment and provide cost-savings. Use of the ADR program in VA has increased to 55 percent which VA estimates has resulted in $81 million in cost avoidance in 2010.

—Build a facilities management system that will maximize life cycle performance and reduce project costs

—Perform audits of the non-VA Care (fee) program expected to identify $4 million in improper payments and further cost avoidance.

—Improve VA/DOD collaboration, and build a corporate analysis and evaluation process to improve analysis and data that drive corporate level decisions.

—Establish the Office of Tribal Government Relations to increase Nation-to-nation partnerships and increase access and awareness and utilization rates of American Indian/Alaska Native veterans and their families.
—Leverage new media tools to improve VA's ability to get the right information to the right veteran at the right time and incorporate their feedback

In addition to strengthening corporate-level oversight, the General Administration account also funds the Board of Veterans Appeals (BVA) and the Office of General Counsel (OGC):

—If the BVA were funded at the fiscal year 2010 level, this would be a reduction of $4.7 million below the budget request. BVA would need to reduce staffing by 35 full-time equivalents which would reduce the number of appeals decided by 5,460 cases and increase the time all veterans must wait for a final decision on appeals of their disability claims.
—Funding OGC operations in fiscal year 2012 at the fiscal year 2010 level would represent a reduction of $3.3 million and 24 full-time equivalents. That would adversely impact OGC's ability to keep pace with an increasing legal workload, including meeting litigation deadlines set by the U.S. Court of Appeals for Veterans Claims (so that veterans would wait longer for decisions), and also keep VA from timely issuing regulations to implement acts of the Congress.

POLYTRAUMA CENTERS

*Question.* Mr. Secretary, I want to commend the VA for the quality of its care to wounded veterans recovering at VA polytrauma centers. I understand that veterans in deep comas at VA polytrauma centers are returning to consciousness at a higher than average rate.

Can you provide the subcommittee with a detailed background of this encouraging development?

Answer. As veterans and servicemembers with catastrophic injuries started coming to the VA Polytrauma Rehabilitation Centers for care, it became apparent that patients who were slow to recover consciousness required a specialized clinical program to address their medical and rehabilitation needs. These patients require high complexity and intensity of medical services and associated resources in order to improve the level of responsiveness and decrease the occurrence of medical complications. Furthermore, there are few programs specifically designed for patients with disorders of consciousness outside of VA.

VA charged a workgroup of subject matter experts from VA, Defense and Veterans Brain Injury Center, and the private sector to develop a specialized emerging consciousness program for veterans and servicemembers who are slow to recover consciousness after severe traumatic brain injury (TBI) and polytrauma. This is a clinical algorithm prescribing the main elements of the medical, nursing, therapy, technology, and family education and support services required for the care of patients in an emerging consciousness state. The Emerging Consciousness Program was implemented in 2007, and is continually updated to reflect advances in medical science.

The VA Emerging Consciousness Programs at the Polytrauma Rehabilitation Centers maintain the highest standards of accreditation and certification for rehabilitation facilities awarded by the Commission on Accreditation of Rehabilitation Facilities. These programs admit both Active-Duty servicemembers and veterans with various forms of acquired brain injury, including TBI, anoxia (or lack of oxygen), stroke, and infectious causes (e.g., encephalopathy). Approximately 65 percent of the admissions have been Active-Duty servicemembers. Of the Active-Duty servicemembers, approximately 45 percent were injured while serving in a foreign theater of operations. Mechanisms of injury have included combat injuries (blast, penetrating), motor vehicle collisions, violence, and metabolic damage from underlying medical conditions.

Retrospective review of outcomes from 121 veterans with impaired level of consciousness admitted to the four Polytrauma Rehabilitation Centers from 2003 through third quarter of 2009 were compiled and analyzed using a research approved protocol. Results showed emergence from coma in 70 percent of veterans with blast related TBI, 85 percent of nonblast-related TBI, and 60 percent with anoxic brain injury. Of those who emerged, 75 percent did so by 4 months post-injury. These results were presented at the American Congress of Rehabilitation Medicine in October of 2010, and are being submitted to medical journals for publication.

## QUESTIONS SUBMITTED BY SENATOR MITCH MCCONNELL

### KENTUCKY COMMUNITY-BASED OUTPATIENT CENTERS

*Question.* Of the contract-run community-based outpatient centers (CBOCs) in Kentucky, what is the level of patient satisfaction with their care?

Answer. [Follows:]

OVERALL SATISFACTION

[Percentage]

| Facility | September 2010 | Fiscal year 2010 average | Fiscal year 2011 year-to-date |
|---|---|---|---|
| Hopkinsville, Kentucky | 89.6 | 55.3 | 53.3 |
| Bowling Green, Kentucky | 28.7 | 49.5 | 41.1 |

*Question.* How is this satisfaction measured, if at all?

Answer. Satisfaction with Department of Veterans Affairs (VA) healthcare is measured using the Survey of Healthcare Experiences of Patients (SHEP). After a healthcare visit, veterans may receive a confidential questionnaire in the mail from VA's Office of Quality, Safety and Value asking about their satisfaction with recent outpatient or inpatient treatment at the specific medical center. The survey is used to communicate any concerns, complaints, compliments, or questions about the care received. Survey responses are compiled in the result of a SHEP score.

To what extent are CBOCs provided incentives to provide good patient care?

Answer. VA has the same high expectations for performance and quality for its CBOCs as for its VA Medical Centers (VAMCs). To enhance staff engagement in quality and process improvement, VAMC and CBOC providers' incentive pay incorporates metrics that reward meeting and exceeding VA-wide performance measures, and their performance plans incorporate performance accountability on these metrics. Performance measures that receive particular emphasis in provider evaluation include measures of veteran access and clinic management for common chronic conditions, such as diabetes, congestive heart failure, and pneumonia.

### HOMELESSNESS

*Question.* What is the VA doing to enhance efforts to locate homeless veterans and to help them?

Answer. VA operates the largest system of homeless treatment and assistance programs in the Nation. The hallmark of VA's homeless programs is that they provide comprehensive care and benefits including medical, psychiatric, substance use, rehabilitation, dental care, and expedited claim processing for these veterans. In the past decade, major VA homeless initiatives on outreach, treatment, residential services, and vocational rehabilitation have touched the lives of tens of thousands of veterans. Outreach, especially to the homeless on the street, is an essential component of VA's plan to end homelessness among veterans. VA's outreach workers engage veterans in the community who are living on the streets and assist them to acquire appropriate services and housing. VA's outreach efforts are also essential in the prevention of homelessness. Identification of a veteran who may be at-risk of homelessness is crucial to keeping that veteran from falling into the cycle of homelessness.

In fiscal year 2010, outreach teams from VA's Health Care for Homeless Veterans (HCHV) Program conducted more than 42,000 clinical assessments and the community-based residential treatment component of this program admitted more than 3,500 homeless veterans. VA provides homeless outreach at all 152 VAMCs and has several programs targeted toward outreach efforts.

*Health Care for Homeless Veterans.*—The central goal of the HCHV Program is to reduce homelessness among veterans by conducting outreach to those who are the most vulnerable and are not currently receiving services and engaging them in treatment and rehabilitative programs. The HCHV Outreach Program has served approximately 90,237 veterans in fiscal year 2010 and more than 36,000 veterans during the first quarter of fiscal year 2011.

*The Health Care for Homeless Veterans Contract Residential Treatment Program.*—The contract residential treatment component of the HCHV Program ensures that veterans with serious mental health diagnoses can be placed in community-based residential treatment programs which provide quality housing and services. HCHV provides "in place" residential treatment beds through contracts with community partners and VA outreach and clinical assessments to homeless veterans

who have serious psychiatric and substance use disorders. The HCHV Contract Residential Treatment Program has served 54,723 unique veterans since 1987; approximately 3,519 veterans were served in fiscal year 2010.

*Stand Downs.*—Stand downs are primarily focused on services. They are collaborative events, coordinated between local VAs, other Government agencies, and community agencies who serve the homeless. Over the years, stand downs have become increasingly crucial components in VA's efforts to outreach to homeless veterans. Since the first stand down was held in San Diego in 1988, literally tens of thousands of veterans have benefited from the array of services made available through these events. During fiscal year 2010, VA assisted in supporting 196 stand down events where 44,325 veterans were served. Thirteen sites held their first stand down in 2010.

*Supportive Services for Veteran Families Program.*—The Supportive Services for Veteran Families (SSVF) Program will make available grant funds for community providers to help veteran families rapidly exit homelessness, or to avoid entering homelessness. In addition to providing linkage to VA healthcare and other services, grantee organizations will have the ability to directly address the type of emergent needs that, if unmet, can be deciding factors in a family's struggle to remain stably housed. Funds for emergency rental assistance, security, and utility deposits, food and other household supplies, child care, one-time car repairs, and other needs will help to keep veterans and their families housed—as families. A notice of funding availability was announced earlier this calendar year and the application period closed on March 11, 2011. VA is in the process of reviewing these applications and awarding grants. VA expects to announce awards in June 2011.

*Veterans Homelessness Prevention Demonstration Program.*—The Veterans Homelessness Prevention Demonstration (VHPD) (also referred to as the HUD–VA Pilot Program) is designed to explore ways for the Federal Government to offer early intervention homeless prevention, primarily to veterans returning from wars in Iraq and Afghanistan. This demonstration program provides an opportunity to understand the unique needs of a new cohort of veterans and will support efforts to identify, outreach, and assist them to regain and maintain housing stability. This 3-year HUD–VA prevention pilot is a partnership among VA, the Department of Housing and Urban Development (HUD), the Department of Labor (DOL), and local community agencies. VHPD will serve the following locations:

—MacDill Air Force Base in Tampa, Florida;
—Camp Pendleton in San Diego, California;
—Fort Hood in Killeen, Texas;
—Fort Drum in Watertown, New York; and
—Joint Base Lewis-McChord near Tacoma, Washington.

As the lead agency, HUD is awarding grants for the provision of housing assistance and supportive services to prevent veterans and their families from becoming homeless, or reduce the length of time veterans and their families are homeless. HUD's Office of Special Needs Assistance Programs executed the grant agreements with the pilot site Continuum of Care grantees on February 3, 2011. The first veterans were seen on April 1, 2011.

*The National Call Center for Homeless Veterans.*—The National Call Center for Homeless Veterans (NCCHV) was founded to ensure that homeless veterans or veterans at risk for homelessness have free, 24/7 access to trained counselors. The hotline is intended to assist homeless veterans and their families, VAMCs, Federal, State, and local partners, community agencies, service providers, and others in the community. The NCCHV (1–877–4AID VET) was fully implemented on March 1, 2010. From March 1, 2010, to February 28, 2011, there were 25,771 calls to the NCCHV. Of the calls received, 20,831 callers identified as veterans; 6,578 veteran callers identified as being homeless; and 11,769 veteran callers identified as being at risk of homelessness.

*Veterans Justice Programs.*—As part of VA's Plan to End Homelessness Among Veterans, VA is focused on serving veterans involved with the criminal justice system, who may be homeless or at risk for homelessness. In fiscal year 2010, the Health Care for Re-Entry Veterans Program and the Veterans Justice Outreach Program continued to provide outreach and linkage to services to justice-involved veterans at high risk of homelessness. Many of these vulnerable veterans were diverted from homelessness and provided healthcare, residential, and benefits assistance. Studies have shown that for adult males, incarceration is the most powerful predictor of homelessness (Burt et al., 2001). The Health Care for Reentry Veterans (HCRV) Program provides outreach and linkage to post-release services for veterans in State and Federal prisons; HCRV specialists have provided reentry services to 24,244 reentry veterans since fiscal year 2008. The Veterans Justice Outreach (VJO) Program focuses on veterans in contact with law enforcement, jails, and courts, in-

cluding the rapidly expanding veterans treatment courts. VJO specialists have served a total of 8,004 justice-involved veterans since the start of the program.

*National Homeless Registry.*—Although not a program itself, VA's comprehensive Homeless Registry is intended to provide up-to-date information about the prevalence of homelessness among veterans and key demographics of the homeless veteran population seen in VA homeless programs. The registry is also intended to provide information regarding VA homeless programs, enabling VA to identify and monitor program utilization and treatment outcomes. VA is working with other Federal partners to expand this capability. The registry includes information on more than 367,230 veterans, and includes data from 2006 to the present.

VA and community partners participated in the 2011 Homeless Point in Time (PIT) Count conducted by the local Continuums of Care. Participation and engagement of VA staff during the PIT Count ensured that homeless veterans were provided immediate information about VA services and programs.

VA continues efforts to identify and contact homeless veterans, improve access to services, create new connections both within and outside VAMCs, and educate healthcare providers and veterans regarding VA homeless services and benefits.

*Women Veterans.*—Women veterans make up nearly 6 percent of homeless veterans. Eleven percent of those accepted for Federal housing vouchers are women. In addition, women veterans are more likely than nonveteran women to become homeless. Risk factors for homelessness among women veterans include mental health conditions, substance abuse, and a prior experience of military sexual trauma. The Women Veteran's Health Strategic Healthcare Group is developing a screening instrument to identify women veterans at risk of homelessness. This screening instrument will identify women at risk, before they become imminently homeless, and enable efficient and timely referral to social and mental health services.

*Question.* What more can be done in this area?

Answer. The VA National Center on Homelessness Among Veterans (NCHV) has adopted a research agenda with a focus on the epidemiology of homelessness among veterans and the effectiveness of services intended to prevent and end homelessness among veterans. These studies are aimed at closing gaps in the research related to the prevalence of homelessness among veterans, characteristics of veterans who experience homelessness, and factors that predict homelessness among veterans as well as veterans' utilization of services and whether these services are both efficient and effective.

The initial studies conducted by the NCHV are focusing on developing a definitive count of homeless veterans. The NCHV collaborated with HUD to develop Veteran Homelessness: A Supplemental Report to the 2009 Annual Homeless Assessment, Report to Congress February 2011 which provides a point-in-time count of homeless veterans in the United States, as well as the characteristics and locations of homeless veterans. An additional investigation by the NCHV of the prevalence and risk of homelessness among veterans in a selection of communities provides more detailed analyses of homelessness risk. These studies suggest that veterans are overrepresented in the homeless population. Specifically, the multi-site investigation found that, after controlling for poverty, age, race, and geographic variation, female veterans were three times as likely as female nonveterans to become homeless, and male veterans were twice as likely as male nonveterans to become homeless.

Another study underway will identify specific risk factors for homelessness among veterans in order to accurately prioritize prevention resources for those who are at imminent risk of homelessness. The NCHV is developing a homelessness risk assessment, which will be piloted in a variety of settings, to include VAMC emergency rooms, CBOCs, and other specialty clinics. The homelessness risk assessment will be tested for reliability and validity. The assessment instrument is a brief, two-stage assessment. It first assesses whether a veteran has a safe and stable place to stay for at least 90 days. If the veteran appears to be at risk, the second stage of the instrument assesses the veteran's current living situation, barriers to living independently, and supports that the veteran may have or require to access and maintain safe and stable housing. The assessment will inform appropriate referrals to homelessness prevention or other services. In addition, data collected through the assessment process will guide decisions regarding need for and targeting of resources moving forward, including specific characteristics that may pose risk for homelessness.

While homelessness among veterans in the Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) service era is a priority concern, there is limited empirical data about the extent to which or dynamics whereby they do become homeless. To address this, the NCHV is examining the onset of homelessness among recent veterans, including those returning from the

OEF and OIF conflicts. Working in conjunction with the VA Office of the Inspector General and municipal shelter providers in Columbus, Ohio; New York City, New York; and Philadelphia, Pennsylvania, researchers at the NCHV are compiling an array of data that will facilitate identifying risk factors for homelessness among OEF/OIF veterans at the time of their separation from the military. This promises to inform prevention programs and potentially increase their efficiency. Service use patterns among this group will also be examined to assess the extent to which they use VA services, community services, or a combination of the two. The review of service use patterns will increase the understanding of how veterans access the services available to them, and may facilitate better coordination of services between VA and mainstream homeless service systems.

The NCHV is also organizing a series of studies around the general topics of mortality, morbidity, and aging among homeless veterans. The overall goal of this project is to assess the demographic trends among the homeless veteran population to project future trends in the size and makeup of this population, and to anticipate future demand for services. Research conducted by study investigators has shown the overall single adult (i.e., not family) homeless population to be steadily aging. If this trend continues, it would lead to higher risk for early mortality and greater needs for long-term care. Research is currently underway to assess whether the trend also holds for homeless veterans, and the impact that providing homeless veterans with housing has on subsequent health and mortality.

WOMEN VETERANS MEDICAL CARE

*Question.* What is the VA doing to assist female veterans?

Answer. VA works to ensure that timely, equitable, and high-quality comprehensive healthcare services are provided in a sensitive and safe environment at VHA facilities nationwide. The VA strives to be a national leader in the provision of healthcare for women.

Since 2009 VA has ensured that full-time women veteran program managers are in place at all VAMCs. These employees are women veteran champions who improve advocacy for women veterans, oversee outreach, and work to improve quality of care by implementing new policies and evidenced-based best practices in healthcare for women.

VHA Handbook 1330.01, released in May 2010, requires that every female veteran have access to primary care from a proficient and interested provider who can provide primary care, gender-specific care, and mental healthcare. VHA is currently assessing the ongoing system-wide enhancement of access to comprehensive primary care with a structured tool and validated external site visits.

Ensuring privacy, dignity, and safety of women veterans in VA healthcare settings is a top VA priority. VA has clarified safety and security policies in VHA Handbook 1330.01 which requires a female chaperone present at all gender-specific examinations and procedures. In addition, VA has been assessing the environment of care on a monthly basis, and tracking correction of any privacy deficiencies.

Another top priority is education of primary care providers to maintain a proficient work force for care of women veterans. VA has educated more than 800 primary care providers in a mini-residency for women's health. Through extensive trainings offered this summer, VA will fulfill the goal of having at least 1,200 providers trained by end of fiscal year 2011. It is important that wherever a woman veteran access VA healthcare she can be seen by a women's health provider for her primary care.

Working with VA researchers, in 2010 VA completed a National Survey of Women Veterans to assess healthcare needs and barriers to care. In addition, in order to benchmark services to women veterans, VA will soon release Sourcebook Volume 1 of the Women's Health Evaluation Initiative which describes the socio-demographic characteristics and healthcare utilization patterns of women veterans.

Ongoing work will improve patient care coordination by improving emergency department care for women veterans, identifying high-risk medications in pregnant or lactating patients, and creating a novel system in the computerized patient medical record system for tracking abnormal mammogram results.

*Question.* What is the VA doing to ensure that female veterans have sufficient privacy during their medical visits to VA facilities?

Answer. Following the Government Accountability Office's (GAO) report, "VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes." (March 2010), VA has undertaken an extensive evaluation of its facilities, identifying existing deficiencies in the environment of care, including bathrooms, privacy curtains, locks, and other areas. These deficiencies have been prioritized and tracked for correction. In fiscal year

2011, VA has budgeted $21 million in nonrecurring maintenance projects that will be used at the facility level to correct bathroom privacy deficiencies in addition to the $241.8 million of gender-specific care (from treatment funds) and $2.89 billion for total care for women veterans. In fiscal year 2010, VA spent more than $214 million in gender-specific care and nearly $2.6 billion in total care for women veterans.

*Question.* What more can be done in this area?

Answer. Access to care, including making care available outside of typical operating hours, continues to be a part of the prospective changes to support ever increasing patient-centeredness of VA healthcare. According to information gathered in March 2011, 29 facilities across 24 States currently offer extended primary care hours for women. Overall, 20.4 percent of facilities offer extended primary care hours (operating hours outside of usual operating hours 8 a.m. to 4:30 p.m.) for women, and 24 percent offer extended primary care hours for men. It is anticipated that these numbers will continue to increase as the transformation to patient-aligned care teams and the focus on more patient-centered care continues.

*Question.* What efforts are being done specifically at Kentucky VA facilities in this vein?

Answer. The Louisville and Lexington VAMCs both have active women veteran's health programs. Full-time women veteran program managers are in place at each facility and are working to improve advocacy, outreach, and quality of care for women veterans. As a result of their efforts, there has been a steady increase in numbers of women veterans using Kentucky VA facilities. In addition, primary care providers from Louisville and Lexington have attended women's health mini-residency training to improve their proficiency in providing comprehensive primary care to women veterans.

WOMEN VETERANS APPOINTMENTS

*Question.* I am informed that the percentage of female veterans who do not show up for their medical appointments is in many cases greater than the percentage of male veterans that do not show up for theirs.

What is the VA doing to better understand why this occurs, and what is being done to reduce this higher percentage?

Answer. VA has been collecting data on no-shows and missed appointment opportunities for several years. While there are small absolute differences in no-show rates by gender, further analysis demonstrates that these differences are not statistically significant.

In 2008, the VHA Under Secretary for Health (USH) released a report that surveyed the current state of healthcare delivery to women veterans. This report called attention to gaps that existed in the care for women veterans, noting that the delivery of primary care for women veterans is frequently fragmented requiring women to travel to multiple locations or make several appointments to receive primary care. Recommendations from the USH report to improve service delivery were incorporated into policy changes outlined in VHA Handbook 1330.01 released in May 2010.

VHA Handbook 1330.01 requires that every female veteran have access to primary care from one provider who can provide primary care, gender-specific care, and mental healthcare. This policy will reduce fragmentation of care and need for women to return for separate appointments for gender-specific services. VA is also evaluating the ongoing system-wide enhancement of access to comprehensive primary care with a structured tool and validated external site visits. Increasing numbers of VA facilities are providing extended hours for women's health services (more than 20 percent of facilities).

VA has conducted a scientifically validated National Survey of Women Veterans to assess barriers to use of VA Care and will soon undertake another national survey of women veterans as required by Public Law 111–163.

VA recognizes that needs of women are different from men and is enhancing facility and clinic designs to better meet the needs of women veterans. The VHA transformation to patient-aligned care teams improves access for women by incorporating alternatives to face-to-face care including increased access to telehealth and e-health communications through the My Healthe Vet secure messaging system. These enhancements will improve access for women veterans as they balance their own needs for healthcare with their priorities for their children and their jobs.

OUTREACH FOR KENTUCKY MEDICAL FACILITY

*Question.* The location of the new VA hospital in Louisville, Kentucky, is of great importance to the local veterans community. In this vein, the VA's initial efforts at

outreach to the veterans community to determine their views on a site location has been poorly planned and executed. Veterans were given little notice about the last public hearing and many were unable to participate. I therefore would urge the VA to better consider the views of local veterans, particularly African-American and younger veterans, in regards to the location of the hospital.

How will the VA improve its outreach efforts in this respect?

Answer. VA is committed to maximizing the dissemination of information to all veterans the Robley Rex VAMC serves. Our efforts were designed with all veterans in mind and are intended to reach all populations.

Two public meetings were conducted on May 11, 2011. The purpose of the meetings was to inform veterans and the general public on the status of the due diligence process and the locations of the five sites under consideration. Methods used to make veterans and the public aware of this event consisted of the following:

—Beginning April 25, 2011, a mass mailing to approximately 45,000 veterans seen by the Robley Rex VAMC was sent advising of the public meeting and inviting them to attend. The mailing was done to ensure all veterans seen by the medical center were aware of the public meeting and invited to attend.

—Letters providing notification of the public meeting date and times were also mailed to veterans service organizations, legislative offices, Kentucky VA, and to the medical center's major affiliates.

—On January 3, 2011 (Frankfort), March 2, 2011 (Frankfort), and April 6, 2011 (Owensboro), the medical center sent representatives to the Joint Executive Council for Veteran Organizations. This also occurred on April 21, 2011, for the VA Voluntary Service meetings to provide status updates on the due diligence process, announce the upcoming public meeting, and answer questions.

—Public notices have been placed in the medical center's volunteer newsletter (May 4, 2011) and local newspaper (May 1, 2011, and May 8, 2011). Media advisories were issued on April 26, 2011, and May 11, 2011.

—Flyers and posters have been placed throughout the medical center and CBOCs.

—The medical center has recently launched an Internet site where visitors, at their convenience, can review progress updates and other related issues.

*Question.* In addition, how are the opinions of local veterans being incorporated into the decisionmaking process of the VA?

Answer. Time will be allowed during both meetings for participants to ask questions and provide comments concerning site preference.

—Verbal comments will be recorded, transcribed, and collated.

—Participants will be provided with a form they may use to prioritize site preferences and provide written comments.

—Participants had the opportunity to submit their preferences/comments either at the public meetings on May 11, 2011, or via mail from May 11–20, 2011.

The medical center is also in the process of conducting another veterans preference survey using a third-party vendor in order to scientifically determine veteran preferences for the five sites under consideration.

Results from the verbal and written comments of the public meeting and the veterans preference survey will be included with the findings and recommendations of the due diligence process and submitted to the Secretary for consideration while making his final decision.

EMPLOYMENT ASSISTANCE

*Question.* With the rate of veterans returning from combat increasing, and with an already high unemployment rate, what is the VA doing to help ensure that these brave servicemembers are able to find jobs when they return to civilian life?

Answer. VA administers a number of programs and works with the Departments of Labor and Defense to assist servicemembers in their transition to civilian life.

VA's Vocational Rehabilitation and Employment (VR&E) Program assists disabled veterans prepare for and obtain sustainable employment. VR&E provides employment services such as:

—Translation of military experience to civilian skill sets;

—Direct job placement services;

—Short-term training to augment existing skills to increase employability (e.g., certification preparation tests and sponsorship of certification); and

—Long-term training including on-the-job training, apprenticeships, college training, or services that support self-employment.

Additionally, under the Coming Home to Work Program, full-time VR&E counselors are assigned to 13 military treatment facilities to assist disabled servicemembers plan their future career.

VA's Post-9/11 GI Bill education benefits cover the cost associated with the education or training needed to help veterans as they transition back into civilian life. This includes tuition and fees, a monthly housing allowance, and an annual books and supplies stipend up to $1,000.

Additionally, VA will work with the DOD and DOL, accrediting agencies, and certifying bodies to ensure that the training and work experience that servicemembers receive will be acceptable for civilian employment.

The Transition Assistance Program (TAP) is a partnership among the Departments of Defense, Veterans Affairs, Transportation, and Labor's Veterans Employment and Training Service (VETS) to provide employment and training information to servicemembers within 180 days of separation and retirement. Servicemembers learn about job searches, career decisionmaking, current occupational and labor-market conditions, resume preparation, and interviewing techniques. They are also receive an evaluation of their employability relative to the job market and information on veterans' benefits.

DOD, DOL, and VA administer a Web site for Wounded Warriors that provides access to thousands of services and resources at the national, State, and local levels to support recovery, rehabilitation, and community reintegration. The National Resource Directory Web site (www.nationalresourcedirectory.gov) provides extensive information for veterans seeking resources on VA benefits, including disability and education benefits.

DEPARTMENT OF VETERANS AFFAIRS HOSPITAL AT EASTERN KENTUCKY

*Question.* I am informed that many veterans in eastern Kentucky are forced to travel several hours to Lexington or Huntington, West Virginia to undergo procedures at VA hospitals.

I would like to know what the feasibility is for a new, centrally located hospital in eastern Kentucky.

Answer. VA bases planning for future healthcare facilities on projected demand for healthcare services by veterans within specific market areas. These projections are obtained from the VA enrollee healthcare projection model, which is produced in partnership with Milliman USA, Inc, the largest healthcare actuarial firm in the United States. Demand for acute inpatient services for veterans in eastern Kentucky is projected to decrease over the next 10 and 20 years, which would make a new, centrally located hospital in eastern Kentucky not feasible. Decreasing demand in patient services is primarily due to changing demographics, as well as continuing shifts in the healthcare industry from inpatient to outpatient care. A hospital sized to meet the small demand would be inefficient to operate and could not offer the breadth and scope of services required to maintain safety and quality of services.

*Question.* What criteria (infrastructure, veterans' population, etc.) does a community need to meet to warrant a VA hospital and what can the eastern Kentucky region do to try to facilitate and hasten construction of a VA hospital there?

Answer. VA engages in thorough and continuous analyses of several factors when planning healthcare delivery in communities. These factors include the enrolled veteran population, the projected demand for healthcare over a 20-year horizon, and existing and planned points of service in that area. Population and demand projections take into account current servicemembers and veterans from ongoing conflicts (OEF/OIF/OND), to include gender-specific healthcare needs. Demand projections address both inpatient and outpatient services, including specialty care.

PRESCRIPTIONS

*Question.* It is my understanding that, based on a November 21, 2006, VA memorandum, that VA officials as a general matter are restricted in their authority to write prescriptions to commercial pharmacies. It is also my understanding that many low-income veterans might benefit from significant cost-savings if their non-service-related prescriptions could be filled at commercial pharmacies.

What is the rationale for this policy?

Answer. The November 21, 2006, memorandum (attached below) does not restrict VA prescribers in their authority to write prescriptions that veterans may have filled in commercial pharmacies. Paragraph 4b on the November 21st memo states: "VA practitioners are permitted to write prescriptions for veterans to be filled in private sector pharmacies, if they meet all prescribing requirements for the State where the prescriptions will be filled.".

The memorandum also provides guidance to VA prescribers to ensure patients do not receive duplicate prescriptions from VA and non-VA pharmacies that the electronic medical record is updated with a reference to the prescriptions being filled

in a non-VA pharmacy and that DEA registration numbers should not ordinarily be used for identification purposes.

Paragraph 4.a prohibits the "transfer" of a prescription previously filled in VA to a non-VA pharmacy. This requirement does not prohibit VA prescribers from writing a new prescription, only from transferring an existing prescription. The reason paragraph 4.a. was included in the memorandum was for safety reasons. If an error were to be made by the non-VA pharmacy in their understanding of the existing VA prescription, the patient could be harmed. For this reason, VA has instructed prescribers to cancel the VA prescription and issue a new one upon the patient's request.

[The memorandum follows:]

**Department of Veterans Affairs** — **Memorandum**

**Date:** November 21, 2006

**From:** Deputy Under Secretary for Health Operations and Management (10N)

**Subj:** Low Cost Prescriptions for Generic Drugs

**To:** Network Director (10N1-23)

1. In late September 2006, Wal-Mart began a pilot in the Tampa, Florida area to provide $4 prescriptions for 30-day supplies of selected generic drugs. The pilot was quickly expanded throughout the state of Florida and is now available in 27 States. Approximately one dozen other large regional and national retail pharmacies are offering similar services.

2. Veterans subject to the $8 VA prescription copayment (for each 30-day supply of medication) are expressing interest in obtaining prescriptions from non-VA sources in order to obtain savings.

3. VHA has convened a work group to examine options for making generic drug co-payments more affordable for veterans. Assuming an acceptable option will be developed and approved, it will take time to implement approved changes.

4. In the interim, the following guidance is provided to assist VHA staff:

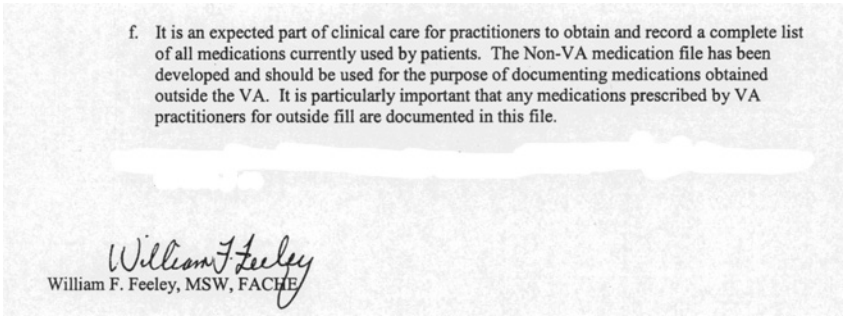
   a. VA pharmacy staff are prohibited from transferring prescriptions to private sector pharmacies, either telephonically or by other means such as FAX and e-mail.

   b. VA practitioners are permitted to write prescriptions for veterans to be filled in private sector pharmacies, if they meet all prescribing requirements for the state where the prescriptions will be filled. When doing so, they must take action to cancel the VA prescriptions to prevent patients from receiving excessive quantities and to record the prescriptions written for non-VA filling in the progress note.

   c. Drug Enforcement Administration (DEA) registration numbers assigned to VA medical care facilities must not be used as practitioner identifiers for the purpose of writing prescriptions to be filled in non-VA pharmacies. Prescribers' personal DEA numbers are to be used for this purpose if required by the non-VA pharmacy. Fees for personal DEA numbers are waived for federal employees, who can register via the DEA website.

   d. Although it is not encouraged, practitioners are permitted to telephone prescriptions to private pharmacies at VA patients' requests, if they meet all State requirements for the state in which the prescription is being filled. Telephoning or otherwise transmitting prescriptions to private pharmacies may not be delegated to other clinical staff and must be documented in the medical record.

   e. In cooperation with VHA Forms staff, VA facilities can develop local prescription blanks to write prescriptions to be filled in non-VA pharmacies. However these blanks are subject to the same security and control requirements as the VA prescription blanks used for internal Schedule II (C-II) prescribing.



f. It is an expected part of clinical care for practitioners to obtain and record a complete list of all medications currently used by patients. The Non-VA medication file has been developed and should be used for the purpose of documenting medications obtained outside the VA. It is particularly important that any medications prescribed by VA practitioners for outside fill are documented in this file.

William F. Feeley, MSW, FACHE

*Question.* What can be done to fix this problem?

Answer. Since there is no prohibition for writing prescriptions to be filled in non-VA pharmacies, we don't believe that corrective action is required.

CLAIMS BACKLOG

*Question.* Although the Congress approved the hiring of more than 1,200 new claims processors for fiscal year 2010, I am told that veterans continue to wait far too long to have their claims processed.

What is the average time between when a claim is filed and when the VA finalizes the process?

Answer. The average time to process a VA disability claim is currently 182 days. A significant factor contributing to the recent increase in processing time is Secretary Shinseki's decision of October 13, 2009, to add three new conditions to disabilities currently presumed related to exposure to herbicides used in the Republic of Vietnam (ischemic heart disease (IHD), Parkinson's disease (PD) and hairy cell (B-cell) leukemia (HCL). While a very positive decision for our veterans, VA must readjudicate previously denied claims for IHD, PD, or HCL filed by Nehmer-class members (Vietnam veterans and their survivors) in order to provide retroactive benefits pursuant to 38 CFR section 3.816. This requirement involves claims filed or denied from September 25, 1985, to the date Secretary Shinseki announced his decision on October 13, 2009. Approximately 93,000 cases were identified fitting this criterion. Due to the complexity of readjudicating claims in this category, all Nehmer readjudication claims are currently being reviewed and readjudicated by the Veterans Benefits Administration's (VBA's) 13 nationwide resource centers, along with some employees at the St. Paul regional office.

VA is also adjudicating a second group of claims under Nehmer provisions that were received between Secretary Shinseki's announcement on October 13, 2009, and the date VA published the final regulation establishing a presumption of service connection on August 31, 2010. Approximately 50,000 cases were received during this period. Completion of these Nehmer claims often requires review of multiple volumes of claims folders to ensure accuracy of effective dates. Unfortunately, there are no technological enhancements to this review process. It is extremely labor-intensive, and one case alone may take 4 to 6 hours to review.

VA currently has 1,300 employees at resource centers around the country devoted to the readjudication of Nehmer claims. Another 1,800 VA employees across VA's 56 regional offices are adjudicating Agent Orange claims received after October 13, 2009. All other regional office employees continue to process non-Agent Orange workload.

*Question.* As the number of veterans and claims continue to increase, what is being done going forward to ensure that claims are processed in a more efficient and timely manner?

Answer. Our approach to transformation is a holistic approach that changes our culture, improves our processes, and integrates innovative technologies. Through our claims transformation initiatives, we are laying technological and business transformation groundwork to streamline claims processing and eliminate the claims backlog. VA's end goal is the Veterans Benefits Management System (VBMS), a smart, paperless, electronic claims processing system.

VBMS will dramatically reduce the amount of paper in the current claims process, and will employ rules-based claims development and decision recommendations where possible. Utilizing automated workflows and business rules engines will prevent common errors, thereby improving quality. Additionally, by using a services-

oriented architecture and commercial off-the-shelf products, VA will be positioned to take advantage of future advances in technology developed in the marketplace to respond to the changing needs of veterans.

While we work to develop the paperless system, we are making immediate changes to improve the efficiency of our business activities. New calculators guide decisionmakers with intelligent algorithms (similar to tax preparation software) or through simple spreadsheet buttons and drop-down menus in evaluating certain medical conditions. A growing body of evidence-gathering tools, called disability benefits questionnaires, brings new efficiencies to collection of medical information needed to rate each claim. The Fully Developed Claims Program speeds the decision process by empowering veterans and helping them submit claims that are ready for VA decision as soon as they are received.

*Question.* Also, what is currently being done to address the massive existing backlog of VA claims?

Answer. VBA increased the claims processing workforce in 2010 by converting 2,400 temporary employees, previously funded through the American Recovery and Reinvestment Act, to full-time employees, and hiring an additional 600 new employees. We currently employ more than 11,000 full-time claims processors. VBA will begin to realize additional gains in production beginning in the fourth quarter of fiscal year 2011 as our new employees complete their training and gain in experience. We are continuing to hire claims processors in fiscal year 2011.

In addition, all veterans service representatives and rating veterans service representatives with more than 1 year of experience in their position are now mandated to perform 20 hours of overtime per month. VBA realized positive results when a similar overtime strategy was implemented to reduce the backlog of education claims in the first year of post-9/11 GI Bill implementation.

VBA recognizes that continuing to increase our full-time equivalent levels is not a sufficient solution. The need to better serve our veterans requires bold and comprehensive business process changes to transform VBA into a high-performing 21st century organization that provides the best services available to our Nation's veterans, survivors, and their families.

VA's multi-tiered approach for addressing the dramatically increasing volume of incoming claims includes a number of innovations. VA deployed two rules-based calculators to streamline and improve decision quality, with more tools in the pipeline. VA is providing veterans with improved online access to claims status information and other self-service options (such as ordering copies of discharge records) through the eBenefits portal. This increases client satisfaction while freeing VA staff to work on claims. A recently deployed Agent Orange (AO) miner tool links AO-related databases together and facilitates data search in developing veterans' AO claims. New evidence-gathering tools are being developed, such as the disability benefits questionnaires, which sharpen the focus in medical examinations to ensure all information needed to rate the claim is gathered the first time in the medical examination process and is presented succinctly. VA's Fully Developed Claims Program operating in all 56 regional offices puts veterans in the driver's seat for submitting claims that are ready to rate when received.

We estimate that in late 2012, production will begin to outpace receipts. At that same time, we plan to begin the deployment phase of the VBMS. VBMS will provide powerful new tools to claims examiners to boost efficiency and productivity. Gains in accuracy through rules-based processing will reduce re-work and appeals. Rules-based processing and calculator tools also speed the rating process, which will increase employee productivity and provide additional staff hours to rate other claims.

POST-TRAUMATIC STRESS DISORDER/TRAUMATIC BRAIN INJURY/MENTAL HEALTH

*Question.* Post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI) continue to be serious conditions for many veterans, as are a host of other mental health issues.

What more can be done to help veterans coping with PTSD, TBI, and mental health issues?

Answer. VA has established a comprehensive system of clinical care for veterans with mental disorders including those veterans who suffer from TBI and other physical problems. These services are fully described in VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, published in 2008. This handbook defines requirements for those mental health services that must be available to all veterans, and those that must be directly provided by VA staff in VA facilities—medical centers, very large, large, mid-sized, and small CBOCs. Uniform access to evidence based clinical care across the VA system is a core feature of VA mental health services, as is a recovery orientation, providing services that

will help veterans with serious mental illness fulfill their personal goals and live meaningful lives in a community of their choice. VA continues to work toward full implementation of the services described in the handbook; we have accomplished most implementation, but efforts remain for full implementation and sustainment.

As of the first quarter of fiscal year 2011, 50.7 percent of OEF/OIF/OND veterans who have come to VAMCs and clinics for care have received a provisional diagnosis of mental disorder. Of these 53.4 percent have a provisional diagnosis of PTSD and 39.3 percent have a provisional diagnosis of depressive disorder. It is clear that mental health issues are prominent among returning servicemembers, but also that PTSD is not the only diagnosis manifested by these veterans.

Recognizing that TBI is another common problem among veterans of the Southwest Asia wars, VA collaborated with the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) to hold a 2-day consensus conference of clinical and scientific experts on April 27–28, 2009. That conference concluded, based on a thorough review of the published evidence, that the assessment and treatment of veterans with co-occurring PTSD and mild TBI could be approached using the evidence-based approaches identified in the VA/DOD clinical practice guidelines. This information is the current standard of practice for these disorders and has been disseminated across the VA system through a variety of face to face, satellite broadcast, and Web-based educational programs. VA mental health and rehabilitation services collaborate to address the needs of veterans with co-occurring PTSD, other mental health problems, and TBI. This coordination is typical of VA's integration of mental health with primary care and other medical services in order to enhance access of veterans to mental health services.

With a clinical infrastructure based on evidence-based assessment and treatment, and enhanced mental health staffing since 2005, VA mental health services are left with two goals—sustaining and expanding the capability to provide these services and promoting access of veterans to these services. Sustaining services is being achieved by tracking the implementation of the Uniform Mental Health Services Handbook. Increasing access is being addressed by initiatives such as providing VA staff at colleges and universities, in a current pilot program, and enhancing availability of VA services in rural areas. Expanding the public's awareness of VA mental health services is being achieved through multiple activities, including (but not limited to):

—Large public outreach campaigns;
—Dissemination of a version of the Uniform Mental Health Services Handbook developed to communicate about required mental health services in language readily understood by veterans and their families;
—Web-based activities such as MyHealtheVet;
—The National Center for PTSD Web site;
—Collaborating with the Caregiver Initiative being implemented by VA Social Work Service;
—Information on VA services and ways to access these services made available through social media such as Facebook;
—A recently released PTSD app for iPhones; and
—Collaborations with community partners, including initiatives such as the VA/DOD Integrated Mental Health Strategy and the Substance Abuse and Mental Health Services Administration Policy Academy Technical Assistance Center.

RURAL ACCESS

*Question.* What is the VA doing to provide improved access to healthcare services for the large population of rural veterans, especially in Kentucky?

Answer. For fiscal year 2011, VA Rural Health Initiative funding of $250 million has been appropriated for National Telehealth/Telemedicine Expansion, Project Access Received Closer to Home, Veterans Rural Resource Centers, Teleradiology Services Sustainment, and veterans integrated service network (VISN) rural initiatives to include outreach clinics and mental health projects.

Approximately 3.3 million veterans enrolled in the veterans healthcare system live in rural and highly rural areas. This represents 41 percent of the approximately 8 million total enrolled veterans. Access to care for rural veterans is increasing which is partly due to the addition of 26 new rural CBOCs. As 25 additional rural CBOCs open, the numbers of enrolled veterans reported are expected to quickly grow.

Rural access is also expanded through opening new rural outreach clinics, mobile units, and telehealth. Data from fiscal year 2009, fiscal year 2010 and fiscal year 2011 quarter one reports show that 416,131 VA encounters/services were provided

for rural veterans, including 8,927 rural OEF/OIF veterans and 11,704 rural women veterans.

The State of Kentucky has seen a steady increase in VHA enrollment for rural veterans, across all enrollment categories. In fiscal year 2010, 269 additional rural veterans enrolled in VHA. The State of Kentucky is part of VISN 9. VA currently funds 11 projects in VISN 9, all designed to expand access to high quality healthcare. Approximately 5,734 VA encounters/services have been provided to/for rural veterans through these projects.

In fiscal year 2010, there were 1,485 veterans in Kentucky that had telehealth-based care in VA clinics; these patients received 3,120 encounters. Of this population receiving clinic-based care via telehealth, 88 percent (1,314) were in rural areas. Currently, as of June 6, 2011, 1,024 veterans in Kentucky are enrolled in VA's home telehealth programs, and 64 percent (656) of these patients live in rural areas.

VA has opened two new rural health CBOCs, expanding both primary and specialty care, and has made significant expansion of available rehabilitation services in the area. VISN 9 is especially proud of expansion of teleretinal screening at the Clarksville CBOC.

With funding from VA, VISN 9 has been a key contributor to the Rural Health Professions Institute (RHPI). RHPI collaborated with Mountain Home VAMC to deliver training to CBOCs and VISN representatives from across the Nation. The RHPI developed new teaching tools and technologies to facilitate understanding of rural culture and delivery of care. RHPI educated staff to the array of VA telehealth technologies, which offered rural veterans the opportunity to receive care from a variety of specialists. Although these projects are not located in Kentucky, they do provide access and care to veterans from Kentucky.

*Question.* What measures are being taken by the VA to expand the use of telemedicine to help rural veterans who lack access to major VA facilities?

Answer. VA provides funding of initiatives that optimize the use of available and emerging technologies to enhance services to veterans residing in rural and highly rural areas. VA continues to fund innovative and diverse pilot projects and service initiatives that improve access and quality of primary, mental health, and specialty care; and enhance care through advances in technology and telehealth services. In addition, the Veterans Rural Health Resource Center—Eastern Region focuses on the education and training of VA and non-VA service providers caring for rural veterans and bringing specialty care to community-based clinics via telehealth technology. In fiscal year 2010, VA telehealth programs provided care to veterans residing in rural and highly rural areas as follows:

—Approximately 20,000 veterans using Home Telehealth;

—Approximately 45,000 veterans using Clinical Video Telehealth; and

—Approximately 77,000 veterans using Store and Forward Telehealth.

VA plans to expand by 50 percent, both its Home Telehealth Program and capacity to undertake clinical consultations using real-time clinical video telehealth in fiscal year 2011. The capability to remotely review clinical digital images via Store and Forward Telehealth (nonradiology) is planned to increase by 30 percent in fiscal year 2011. VA also has other specific initiatives to expand the scope of its telehealth services that include:

—Spinal cord injury (Tele-SCI);

—Audiology (Tele-audiology); and

—Pathology (Tele-pathology) clinical consultation networks.

VA is developing a rural telehealth communications plan, which will include an annual report of accomplishments. The products and tool developed as a result of the communication plan will be distributed VHA-wide. VA places the highest priority on telehealth services and will continue to support expansion of telehealth services nationally.

FORT KNOX IRELAND COMMUNITY-BASED OUTPATIENT CLINIC

*Question.* I am informed that DOD will begin budgeting for the replacement of the Fort Knox Ireland Army Community Hospital in fiscal year 2013. Currently, Ireland has a CBOC affiliated with it.

What steps are being taken by the VA to ensure that efforts on the CBOC are synchronized with those of DOD and the new hospital?

Answer. There is an ongoing dialogue between the VA and DOD concerning this issue. Efforts are being coordinated through the VA's DOD-sharing office and involve discussion at both the local and national levels. VA is developing a business case to best address the needs of veterans served by the CBOC at Fort Knox, which will be evaluated in VA's strategic capital investment planning process.

SUBCOMMITTEE RECESS

Senator JOHNSON. This hearing is concluded.

[Whereupon, at 11:54 a.m., Thursday, March 31, the subcommittee was recessed, to reconvene subject to the call of the Chair.]